* of spleen & perf. wd. left dome of diaphragm.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 166

00104

CERTIFICATE OF DEATH

Reg. Dist. No. 27

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Fort George G. Meade, Maryland (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? nine days

Hospital, institution, or street address where death occurred: Station Hospital, Fort George G. Meade, Md.

How long in hospital or institution? Six hours

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: KANSAS County:

City or town: Junction City (If outside city or town limits, write RURAL and give nearest town)

Street No. 332 W First Street (If rural, give LOCATION)

2.(a) If veteran, name war: Regular Army Soldier (World War II)

3.(a) FULL NAME: RICHARD J. ABNEY

3.(b) Social Security Number: -

4. Sex: Male

5. Color or race: White

6.(a) Single, married, widowed, or divorced: Married

6.(b) Name of husband or wife: Margaret Abney

6.(c) If alive, give age: 21 years

7. Birth date of deceased (mo., day, yr.): May 28, 1918

8. AGE: Years: 28 Months: 7 Days: 9 If less than one day: ... hrs. ... min.

9. Birthplace: Grundy County, Iowa (Town, county, and state)

10. Usual occupation: Soldier, Regular Army (Civ: Police-/man)

11. Industry or business: Regular Army (Sgt, RA6912352)

FATHER

12. Name: -

13. Birthplace: -

MOTHER

14. Maiden name: (Foster mother) Emma Brainard

15. Birthplace: -

16. Informant: U. S. Army/& Medical Service Records

Address: Fort George G. Meade, Maryland

17. Removal (Burial, cremation, or removal. Which?) Date thereof: 1/8/47 (month) (day) (year)

Cemetery or crematory: Johnson Funeral Home

Location: Junction City, Kansas

18. Funeral director: Howard Blight Jr.

Address: 4914 Be[illegible]

19. 7 January 1947 (Date rec'd by registrar) Bernard F. Kerwin — BERNARD F. KERWIN, Capt., PC Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 7 January 1947, at 5:15 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 6 January 1947 to 7 January 1947 and that I last saw him alive on 7 January 1947

Immediate cause of death: Pulmonary hemorrhage & pulmonary collapse secondary to bullet wounds of chest Wounds, multiple, perforation

(cal. 45) Pt of entrance was posterior

Due to: thorax 1 cm to the rt of the mid-line level of the ninth dorsal vertebra

Other conditions: (rt auricle, and pericardium), pt of exit right anterior chest 5 cm from mid line of the margin of 5th dorsal cart-/liage.

DURATION

Major findings of operations: Multiple perf. of transverse colon, lac. *(top) Date of op. 7 Jan. 1947

Autopsy results: Confirmed as above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Homicide Date of: 6 Jan. 1947

Where did injury occur? Fort George G. Meade (City or town) Anne Arundel County (County) Maryland (State)

Injured at home, farm, industry, public place (where?) Main bus station on /post

Means of injury: Bullet wounds Injured at work? No

23. SIGNATURE: James G. Jackson Capt MC — JAMES G. JACKSON, Capt., M.C. M.D. or other

Address: Sta. Hosp., Ft. G G Meade, Md. Date signed: 8 Jan 47

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

00105

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Diat. No. 21

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Use correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Annapolis
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Life
Hospital, institution, or street address where death occurred: 111 South Street
How long in hospital or institution? ---

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Anne Arundel Co.
City or town: Annapolis
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 111 South Street
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Emma Dorsey Baden

3.(b) Social Security Number: 578-14-3213

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Colored	Married

6.(b) Name of husband or wife: Alfred A. Baden
6.(c) If alive, give age: ... years

7. Birth date of deceased (mo., day, yr.): November 29, [illegible] 1906

8. AGE: Years	Months	Days	If less than one day
40	1	20	... hrs. ... min.

9. Birthplace: Annapolis Maryland
(Town, county, and state)
10. Usual occupation: General House work
11. Industry or business: None

FATHER
12. Name: Clam Dorsey
13. Birthplace: Prince George Co. Md.

MOTHER
14. Maiden name: Elizabeth Oewens
15. Birthplace: Prince George Co. Maryland

16. Informant: Alfred Baden
Address: 111 South Street

17. Burial (Burial, cremation, or removal. Which?) Date thereof 1- 21- 1947 (month) (day) (year)
Cemetery or crematory: Brewer Hill
Location: West Street Extended
18. Funeral director: Mrs. Charles E. Hicks
Address: 43-45 Northwest Street

19. Jan. 20 1947 (Date rec'd by registrar) [signature] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Jan 18 1947 at 8:20 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 10-4-46 1946 to 1-18 1947 and that I last saw h[illegible] alive on 1-16-47 1947

Immediate cause of death	DURATION
Uterine Cancer	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operation: ... Date of op. ...
Autopsy results: ...
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ... Date of ...
Where did injury occur? ... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) ...
Means of injury ... Injured at work?

23. SIGNATURE: C. T. Adams M.D. M. D. or other
Address: 17 Carroll St. Date signed 1-20 47

1-35

MARYLAND STATE DEPARTMENT OF HEALTH BC 00106

2411 N. Charles St., Baltimore 13F

CERTIFICATE OF DEATH

Reg. Diat. No. 280

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Give correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH: An. Ar.

County Crownsville State Hospital

City or town Crownsville, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 21 yrs. 7 mos. 22 days

Hospital, institution, or street address where death occurred:
Crownsville State Hospital, Crownsville, Md.

How long in hospital or institution? 21 yrs. 7 mos. 22 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Baltimore City County

City or town
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Frank Ball

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Negro	Single

6.(b) Name of husband or wife —

6.(c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) 1890 ?

8. AGE: Years	Months	Days	If less than one day
56 ?	?	?	hrs. min.

9. Birthplace Virginia
(Town, county, and state)

10. Usual occupation Laborer

11. Industry or business —

FATHER 12. Name Robert Ball

13. Birthplace Virginia

MOTHER 14. Maiden name Ella Ball (?)

15. Birthplace Virginia

16. Informant Hospital Records Crownsville State

Address Hospital, Crownsville, Maryland

17. Buried (Burial, cremation, or removal. Which?) Date thereof Feb. 2, 1947 (month) (day) (year)

Cemetery or crematory Old St. John Cemetary

Location Kilmarcek, Virginia

18. Funeral director Joseph L. Russ

Address 1200 McCulloh St. Baltimore, Maryland

19. Jan 31 1947 (Date rec'd by registrar) E. T. Joyce Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH January 30 1947 at 9:45 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 8 1925, to January 30 1947 and that I last saw him alive on January 30 1947

Immediate cause of death Tuberculosis of Lungs — DURATION: Known to us since January 1947

Due to

Due to

Other conditions Dementia Praecox — Known to us since 6/8/25

(Include pregnancy within 3 months of death)

Major findings of operations Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Herbert V. Brickrode M. D. or other

Address Crownsville State Hospital Date signed 1/31/47

1-35

00107

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Diat. No. 21

1. PLACE OF DEATH:
County Anne Arundel
City or town Annapolis Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred: Emergency Hospt.
How long in hospital or institution

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Anne Arundel
City or town Annapolis
(If outside city or town limits, write RURAL and give nearest town)
Street No. 15 Franklin St.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME Ella Basil

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Single

6.(b) Name of husband or wife

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 4th 1872

8. AGE: Years 74 Months 6 Days 13 If less than one day hrs. min.

9. Birthplace Annapolis Md
(Town, county, and state)

10. Usual occupation nurse (retired)

11. Industry or business

FATHER
12. Name Joseph S. Mc. Basil
13. Birthplace Maryland

MOTHER
14. Maiden name Margaret Ann Mitchell
15. Birthplace Annapolis Md

Informant Mrs Hugh R. Riley
Address 15 Franklin St. Annapolis Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Jan 21st 1947 (month) (day) (year)
Cemetery or crematory St Anns
Location Annapolis Md
18. Funeral director John M. Taylor, Son
Address Annapolis Md.

19. Jan. 20 1947 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH January 18 1947 at 4:45 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 8 1947 to Jan 18 1947 and that I last saw h[illegible] alive on Jan 18 1947

Immediate cause of death	DURATION
Cerebral Apoplexy	10 Days
Due to Arterio Sclerosis	Unknown
Due to Natural Hypertension	Several yrs.
Other conditions Hemiplegia right side Paralysis	

(Include pregnancy within 3 months of death)

Major findings of operations Date of op
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE C. Oliver Pursell M.D.
M. D. or other
Address Annapolis Md Date signed 1/19/47

PLEASE WRITE PLAINLY. IF CAUSE IS ACCIDENTAL, VIOLENT OR SUSPICIOUS, STATE SO. Supply every item of information carefully. The cause of death is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

93d

00108

CERTIFICATE OF DEATH

Reg. Dist. No. 2

1. PLACE OF DEATH:

County A.A.

City or town Annapolis
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 28 Years

Hospital, Institution, or street address where death occurred:
22 Madison. Street

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County A.A.

City or town Annapolis,
(If outside city or town limits, write RURAL and give nearest town)

Street No. 22 Madison
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME John T. Basil

3.(b) Social Security Number

4. Sex	5. Color or race	8.(a) Single, married, widowed, or divorced
M	W	Married

6.(b) Name of husband or wife Celinda Basil

6.(c) If alive, give age 61 years

7. Birth data of deceased (mo., day, yr.) Aug 31 1877

8. AGE: Years	Months	Days	If less than one day
69 ~~61~~	4	6	....hrs. ....min.

9. Birthplace Annapolis
(Town, county, and state)

10. Usual occupation Stock Clerk

11. Industry or business

FATHER
12. Name John W. Basil
13. Birthplace Annapolis,

MOTHER
14. Maiden name Anna Deale
15. Birthplace Annapolis

16. Informant Mrs Celinda Basil
Address 22 Madison Street. Annapolis,

17. Burial (Burial, cremation, or removal. Which?) Date thereof Jan 8 1947 (month) (day) (year)

Cemetery or crematory Cedar Bluff

Location Annapols, Maryland.

18. Funeral director B.L. Hopping & Son

Address Annapolis, Maryland.

19. Jan. 7, 1947 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 6 1947 at 5-9 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 1943 to Jan 6 1947 and that I last saw h.. alive on Jan 6 1947

Immediate cause of death	DURATION
Acute Dilatation of Heart.	Sudden
Due to Myocarditis Ch.	Several years.
Due to Collateral asthma	
Other conditions Arteriosclerosis	Several years.

(Include pregnancy within 3 months of death)

Major findings of operations Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE George C. Basil
M. D. or other

Address Annapolis Md Date signed 1-6-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

161a ★ 00109

Reg. Diat. No. 24

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Annapolis Md.

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred: Emergency Hospt.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infant give residence of mother)

State: Maryland County: Anne Arundel

City or town: West Annapolis

(If outside city or town limits, write RURAL and give nearest town)

Street No.: A. A. Co Md.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Baby Bembe

Mary Elizabeth

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Single

6.(b) Name of husband or wife

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): Jany 23d 1947

8. AGE: Years — Months — Days — If less than one day: 1 hrs. min.

9. Birthplace: Annapolis Md

(Town, county, and state)

10. Usual occupation: None

11. Industry or business

FATHER — 12. Name: Albert Bembe

13. Birthplace: Eastport Md.

MOTHER — 14. Maiden name: Mary Colburn

15. Birthplace: W. Annapolis A.A. Co Md.

16. Informant: Albert Bembe

Address: West Annapolis A A Co Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Jan 25th 1947 (month) (day) (year)

Cemetery or crematory: Cedar Bluff

Location: Annapolis Route 1.

16. Funeral director: John W. Taylor Son

Address: Annapolis Md.

19. Jan. 25, 1947 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Jan. 23, 1947 at 3:45 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1-23- 1947, to 1-23 1947

and that I last saw h[illegible]ative on 1-23- 1947

Immediate cause of death: Asphyxia Neonatorum — DURATION: 1 hr.

Due to:

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following.

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: James R. Martin, M.D. M. D. or other

Address: 185 Prince George St Annapolis Md. Date signed 1-24-47

1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

1642

00110

CERTIFICATE OF DEATH

Reg. Dist. No. 28

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Crownsville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 1 year
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Anne Arundel
City or town: Herald Harbor, Crownsville
(If outside city or town limits, write RURAL and give nearest town)
Street No.: Beech Tree Road.
(If rural, give LOCATION)
2.(a) If veteran, name war: World War II

3.(a) FULL NAME: Charles Binkley

3.(b) Social Security Number: 577-38-9749

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	White	married

6.(b) Name of husband or wife: Virginia L. Binkley
6.(c) If alive, give age: ... Years

7. Birth date of deceased (mo., day, yr.): Feby. 1, 1912

8. AGE: Years	Months	Days	If less than one day
34	11	3	... hrs. ... min.

9. Birthplace: Bath, Allen County, Ohio
(Town, county, and state)
10. Usual occupation: Driver.
11. Industry or business: Annapolis Dairy

FATHER
12. Name: not Known
13. Birthplace:

MOTHER
14. Maiden name: Eva Binkley
15. Birthplace: not Known

16. Informant: Copy of Birth Certificate
Address: Bath, Allen County, Ohio

17. Burial (Burial, cremation, or removal. Which?) Date thereof Jan. 7, 47 (month) (day) (year)
Cemetery or crematory: National Cemetery
Location: Annapolis, Maryland

18. Funeral director: John W. Taylor Jr.
Address: Annapolis Maryland

19. January 6 1947 E. Joyce Long
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Jany. 4 1947, at ... M

21. I CERTIFY that death occurred on the date above stated, ~~and that I last saw deceased alive on~~ Postmortem Examination Jany. 4 1947

Immediate cause of death	DURATION
Bullet Wound in Head.	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ... Date of op ...
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Suicide Date of 1/4/47
Where did Injury occur? Herald Harbor, (City or town) A.A.Co., (County) Maryland (State)
Injured at home, farm, industry, public place (where?) at Home
Means of Injury 25 cal. bullet Injured at work? no

23. SIGNATURE: John M. Cleffy M.D. Deputy medical Examiner
M. D. or Other
Address: Annapolis, Md. Date signed 1/4/47

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

I-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

46g

00111

Reg. Dist. No. 21

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Use correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:
County A. A.
City or town Annapolis
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
Emergency Hospital
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md County A. A.
City or town Annapolis
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Alverta Boston

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Colored	widow

6.(b) Name of husband ~~or wife~~ Edward Boston
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Aug. 29 1882

8. AGE: Years	Months	Days	If less than one day
64	4	9	....hrs. ....min.

9. Birthplace West River A. A. Co
(Town, county, and state)
10. Usual occupation Domestic
11. Industry or business
FATHER 12. Name Richard Jones
13. Birthplace Md
MOTHER 14. Maiden name Margrete Jones
15. Birthplace Md.
16. Informant Rosetta Butler
Address P.O. Mayo. Md
17. Burial (Burial, cremation, or removal. Which?) Date thereof Jan 12 1947 (month) (day) (year)
Cemetery or crematory St. Marks
Location Mayo Md
18. Funeral director J. B. Johnson
Address Annapolis
19. Jan. 10 1947 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 9 1947, et ..... M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
12-22- 1946, to 1-9- 1947
and that I last saw h.e.r. alive on 1-9- 1947

Immediate cause of death
1) Hypertension C.V.D.
Due to
b) Pneumonia Pneumonia
Due to
Other conditions

(Include pregnancy within 3 months of death)

Major findings of operation
Date of op.
Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

DURATION

22. VIOLENCE: If death was due to external causes, fill in the following
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE L. Lenhardt M. D. or other
Address Annapolis Md Date signed 1-10-47

SURNAME: Letter from Dr. Winterode, Supt. Crownsville filed 1-16-47 G106 LE

B

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

938

00112

Reg. Dist. No. 38

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Crownsville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? one year 8 months 3 days
Hospital, institution, or street address where death occurred: State Hospital Crownsville Md
How long in hospital or institution? one year, 8 months, 3 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: ?
City or town: ?
(If outside city or town limits, write RURAL and give nearest town)
Street No.: ?
(If rural, give LOCATION)
(a) If veteran, name war: ?

3. (a) FULL NAME: (Jim) James Boller, alias Jim Boller

3. (b) Social Security Number: ?

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Black	?

6.(b) Name of husband or wife: ?
6.(c) If alive, give age: ? years

7. Birth date of deceased (mo., day, yr.): ?

8. AGE: Years: 56 years | Months: ? | Days: ? | If less than one day: ? hrs. ? min.

9. Birthplace: Maryland (Town, county, and state)

10. Usual occupation: laborer

11. Industry or business: ?

FATHER
12. Name: Dan Boller, dead
13. Birthplace: ?

MOTHER
14. Maiden name: Lucy Boller
15. Birthplace: ?

16. Informant: Mary Stevenson daughter
Address: 1420 Harford Ave, Balto 2

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Jan 15, 1947 (month) (day) (year)
Cemetery or crematory: Old Calvary Cem
Location: A. G. County
18. Funeral director: Raymond Sanders
Address: 1412 E Preston Street

19. 1/14 1947 H. W. Hedrick M.D. Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: January 11th 1947 at 11 55 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 8th 1945 to January 11th 1947 and that I last saw h. i. alive on January 11th 1947

	DURATION
Immediate cause of death: chronic hypocardities	known to us since May 8th 1945
Due to: psychosis with	
Due to: generalized art	
Other conditions: cerebral arterio-sclerosis	

(Include pregnancy within 3 months of death)

Major findings of operations: ——— Date of op. ———

Autopsy results: none

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: none Date of ———
Where did injury occur? ——— (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) ———
Means of injury ——— Injured at work? no

23. SIGNATURE: Herbert J. Winterode M. D. or other
Address: State Hospital Crownsville Date signed: 1/11/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

93d

00113 P

CERTIFICATE OF DEATH

Reg. Dist. No. 21

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Severna Pk
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 7 yrs
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md County:
City or town: Severna Pk
(If outside city or town limits, write RURAL and give nearest town)
Street No.: Riggs & Long Ave
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Minnie W. Bowling

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	W

6.(b) Name of husband or wife: Jacob L Bowling
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Aug 3, 1870

8. AGE: Years: 76 Months: 5 Days: 27 If less than one day: hrs. min.

9. Birthplace: Baltimore
(Town, county, and state)

10. Usual occupation: none

11. Industry or business

FATHER
12. Name: Unknown
13. Birthplace: Germany

MOTHER
14. Maiden name: Minnie —
15. Birthplace: Germany

16. Informant: Mrs. Gertrude B. Thompson
Address: Riggs Ave & Long Ln Severna Park

17. (Burial, cremation, or removal. Which?) Date thereof (month) (day) (year)
Cemetery or crematory: Trinity
Location: Baltimore

18. Funeral director: Philip Stewart Sons
Address: 2024 Orleans St

19. Jan 31 1947 (Date rec'd by registrar) C. W. Hedrick Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Jan 30 1947, at 6 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan. 10 1947, to Jan 30 1947 and that I last saw h[illegible] alive on Jan 26. 1947

	DURATION
Immediate cause of death: Acute Oedema of the Lungs	12 hours
Due to: Cardio-vascular Disease	2 years
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: none

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: James S. Bullington MD
M. D. or other
Address: Glen Burnie Md Date signed: Jan 31, 1947

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

00114

Reg. Diat. No. 201

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Mt Zion

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Life

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Anne Arundel

City or town: Rural - Mt Zion

(If outside city or town limits, write RURAL and give nearest town)

Street No.: 2 miles North Mt Zion.

(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: Horsey Wyville Brady, Sr.

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	Married

6.(b) Name of husband or wife: Emma Henrietta Brady

6.(c) If alive, give age: 57 years

7. Birth date of deceased (mo., day, yr.): April 21 1879 ~~April 21, 1899~~

8. AGE:

Years	Months	Days	If less than one day
67	9	1	..... hrs. ..... min.

9. Birthplace: Calvert County Md (Town, county, and state)

10. Usual occupation: Farmer

11. Industry or business: Agric.

FATHER

12. Name: Samuel Jackson Brady

13. Birthplace: Calvert County

MOTHER

14. Maiden name: Martha Anne Chaney

15. Birthplace: Calvert County.

18. Informant: Horsey Wyville Brady Jr

Address: Three Mile Oak RFD #1 Annapolis Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof Jan 23 '47 (month) (day) (year)

Cemetery or crematory: St. Lukes

Location: Bayard Maryland

18. Funeral director: L. E. Hopkins & Son

Address: Annapolis. Md

19. 1/23 1947 (Date rec'd by registrar) W. M. Clayton Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 21 Jan 1947 at 9:35 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 15 1947, to 21 Jan 1947

and that I last saw h.. alive on 21 Jan 1947

	DURATION
Immediate cause of death: Cerebral Vascular Accident - Hemorrhage	4 days
Due to: Arteriosclerotic Cardiovascular disease	Unk
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Robert B. Jones M.D. M. D. or other

Address: Upper Marlboro Md Date signed: 21 Jan 47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

1-55

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

00115

Reg. Dist. No. 21

1. PLACE OF DEATH:

County: M. C. Co.

City or town: Lesenna Park

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Fifty Years

Hospital, institution, or street address where death occurred: Not

How long in hospital or institution? No

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: M. C. Co.

City or town: Lesenna Park.

(If outside city or town limits, write RURAL and give nearest town)

Street No.: Rural

(If rural, give LOCATION)

2.(a) If veteran, name war:

3. (a) FULL NAME: Joseph McCourney Brenan

3. (b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	Single

6.(b) Name of husband or wife: Single

7. Birth date of deceased (mo., day, yr.): June 4, 1888

6.(c) If alive, give age: Single years

8. AGE: Years: 58 | Months: 7 | Days: 20 | If less than one day: hrs. min.

9. Birthplace: Baltimore Md (Town, county, and state)

10. Usual occupation: Coal Business

11. Industry or business: Coal

FATHER

12. Name: Edward M. Brenan

13. Birthplace: Baltimore Md.

MOTHER

14. Maiden name: Mary Anna T. McCourney

15. Birthplace: Queen Anne County

16. Informant: Mamie M. Brenan

Address: Lesenna Parkroad

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Jan. 27 1947 (month) (day) (year)

Cemetery or crematory: Cathedral

Location: Balto md

18. Funeral director: Henry W Jenkins Son Co

Address: Orchard & Monument st

19. Jan. 25, 1947 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: January 24, 1947 at 8:30 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 5, 1947 to January 24 1947; and that I last saw him alive on January 22 1947

Immediate cause of death	DURATION
Acute dilatation of the heart	9 minutes
Due to	
Due to	
Other conditions: Diabetes Mellitus	14 yr.

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Albert L Anderson M.D. M. D. or other

Address: Annapolis Md Date signed: 1/25/47

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1-35

Evidence for the change of age is shown on G 108 1/20/47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

732 00116

Reg. Dist. No. 250

1. PLACE OF DEATH:
County: A A County
City or town: Brooklyn Park Md
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred:
12 W. First Ave.
How long in hospital or Institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md County: A. A. Co.
City or town: Brooklyn Park Md
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 12 W. First Ave - 25
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Howard Bimmer Sr

3.(b) Social Security Number: 218-03-3144

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widower

6.(b) Name of husband or wife: Elizabeth Bimmer

6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): April 7 - 1872

8. AGE: Years	Months	Days	If less than one day
74 1787	—	—	..... hrs. ..... min.

9. Birthplace: Balto Md (Town, county, and state)
10. Usual occupation: Watchman
11. Industry or business: Federal Housing Authority
FATHER 12. Name: John Bimmer
13. Birthplace: Germany
MOTHER 14. Maiden name: Elizabeth J Knight
15. Birthplace: Balto Md
16. Informant: Howard Bimmer Jr.
Address: 4026 Pennington Ave
17. Burial (Burial, cremation, or removal. Which?) Date thereof: Jan 4-47 (month) (day) (year)
Cemetery or crematory: Woodlawn
Location: Woodlawn Md
18. Funeral director: Milton Schilling
Address: 3414 Hanover At-25
19. Jan 2 1947 (Date rec'd by registrar) John M. Whitman Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Jan 1st 1947, at 5.15 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 1 1947, to Jan 1 1947
and that I last saw h— alive on Jan 1 1947

Immediate cause of death	DURATION
Anemia	
Due to Hypertension	
& Hydrocephalus	
Due to Heart disease	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Sam A Rubin M.D.
M. D. or other
Address: 903 Patapsco Ave. Date signed:

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

00117

Reg. Dist. No. 21

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Annapolis
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Life
Hospital, institution, or street address where death occurred:
Emergency Hospital
How long in hospital or institution? 24 Hours

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Anne Arundel
City or town: Annapolis
(If outside city or town limits, write RURAL and give nearest town)
Street No. 22 Gotts Court
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Nathaniel Brown

3.(b) Social Security Number: 214-05-0676

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colored	Single

6.(b) Name of husband or wife:
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): June 14, 1901

8. AGE: Years	Months	Days	If less than one day
45	7	7	hrs. min.

9. Birthplace: Annapolis Maryland
(Town, county, and state)
10. Usual occupation: Laborer
11. Industry or business: None

FATHER
12. Name: James Brown
13. Birthplace: Annapolis Maryland

MOTHER
14. Maiden name: Charlotte Murdock
15. Birthplace: Annapolis, Maryland

16. Informant: Lillian Murdock
Address: 148 W. 141 Street New York City

17. Burial (Burial, cremation, or removal. Which?) Date thereof 1-26-47 (month) (day) (year)
Cemetery or crematory: Brewer Hill
Location: West Street Extended
18. Funeral director: Mrs. Charles E. Hicks
Address: 43-45 Northwest Street

19. Jan. 25, 1947 (Date rec'd by registrar) [signature] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 1-21-47, 19..., at 4 45 D M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1-20- 19 47, to 1-21- 19 47
and that I last saw h[illegible] alive on 1-21-47 19

Immediate cause of death	DURATION
Coronary Occlusion	1 day
Due to: Myocarditis, Chron	2 Yrs?
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: James R. Martin, M.D. M. D. or other
Address: 85 Prince George St. Date signed 1-23-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

00118 P

94a ★ 21

CERTIFICATE OF DEATH

Reg. Dist. No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Riviera Beach
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? part of day
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Anne Arundel
City or town: ~~Glen~~ Riviera Beach
(If outside city or town limits, write RURAL and give nearest town)
Street No.: Glen Road
(If rural, give LOCATION)
2.(a) If veteran, name war: W

3.(a) FULL NAME: Paul Brunk

3.(b) Social Security Number: NONE

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	married

6.(b) Name of husband or wife: Anna Brunk
6.(c) If alive, give age: 53 years

7. Birth date of deceased (mo., day, yr.): Nov. 7, 1879

8. AGE: Years	Months	Days	If less than one day
67	2	10	..... hrs. ..... min.

9. Birthplace: Germany (Town, county and state)
10. Usual occupation: Fisherman
11. Industry or business: Fishing

FATHER
12. Name: Ferdinand Brunk
13. Birthplace: Germany

MOTHER
14. Maiden name: Wilhelmena Loose
15. Birthplace: Germany

16. Informant: Mrs. Anna Brunk
Address: Glen Road, Riviera Beach, Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof 1/21/47 (month) (day) (year)
Cemetery or crematory: Meadow Ridge
Location: Dorsey, Md.

18. Funeral director: Tilton & Son
Address: 1217 E. Pont St

19. 1-20-47 (Date rec'd by registrar) D. Moudis Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Jany. 17 1947, at 5:30 P.M.

21. I CERTIFY that death occurred on the date above stated: ~~that I attended deceased from~~ Post mortem Examination
~~and that I last saw him alive on~~ Jany. 18 1947

Immediate cause of death	DURATION
Coronary embolism	sudden
Due to: Arterio-sclerosis	unknown
Due to: Coronary sclerosis	unknown
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: John M. Coffey M.D. Deputy Medical Examiner
M. D. or other
Address: Annapolis, Md Date signed 1/18/47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 00119 21

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Annapolis, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2½ months

Hospital, institution, or street address where death occurred:
U.S. Naval Hospital, Annapolis, Md.

How long in hospital or institution? 2½ months

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Baltimore

City or town: Baltimore, Maryland
(If outside city or town limits, write RURAL and give nearest town)

Street No. 1536 N. Bond Street
(If rural, give LOCATION)

2.(a) If veteran, name war: World Wars 1 and 2. ✓

3.(a) FULL NAME: William Oland BYUS

3.(b) Social Security Number: NONE

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Lillian M. Byus

6.(c) If alive, give age: 49 years

7. Birth date of deceased (mo., day, yr.): July 7, 1894

8. AGE: Years	Months	Days	If less than one day
52	6	24	....hrs. ....min.

9. Birthplace: Baltimore, Maryland
(Town, county, and state)

10. Usual occupation: U.S. Navy (Retired- Inactive)

11. Industry or business:

FATHER
12. Name: John O. Byus
13. Birthplace: Maryland

MOTHER
14. Maiden name: Ella Shorter
15. Birthplace: Maryland

16. Informant: Mrs. Lillian M. Byus
Address: 1536 N. Bond Street

17. Burial (Burial, cremation, or removal. Which?) Date thereof: 2/4/47 (month) (day) (year)

Cemetery or crematory: Baltimore National Cemetery

Location: Baltimore, Maryland

18. Funeral director: HENRY SANDER & SONS, INC.

Address: NORTH AVE. & BROADWAY

19. ....., 19.... (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: January 31, 1947, at 6:52 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from November 17, 1946, to January 31, 1947 and that I last saw him alive on January 31, 1947

Immediate cause of death	DURATION
Carcinoma, metastatic	
Due to	
Due to	
Other conditions: Diabetes mellitus	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results: Generalized abdominal carcinomatosis; primary site was not definitely determined, but microscopic findings were compatible with Carc. of the G. I. Tract, probably sigmoid

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ..... Date of 1/16/48

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: N. L. Bline
N. L. BLINE, LTJG. MC. USNR. M. D. or other

Address: U.S.N.H., Annapolis, Md. Date signed: 1-31-47

Evidence is shown on film for member of the [redacted]

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 23 P

S109 - 2/26/47

1. PLACE OF DEATH: 2nd Co
(a) ~~Baltimore City~~, Maryland
(b) Street address: Pumphrey + Balto. Highway
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore (If outside city or town limits, write RURAL and give town)
(d) Street No. 2126 Penrose Ave (If rural give location)
(e) Citizen of foreign country? (Yes or No) If yes, name country

3 (a) FULL NAME: Bertha Calliflower

3 (b) If veteran, name war

3 (c) Social Security Account No. 212-05 7997

4. Sex: Female | 5. Color or race: White | 6 (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Norbert

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 26 1911

8. AGE: Years 35 | Months | Days | If less than one day hr. min.

9. Birthplace D.J.m Baltimore, Md. (Town, county, and state)

10. Usual Occupation Sailor

11. Industry or business

FATHER
12. Name Alexander S. Pugzentas
13. Birthplace Lith

MOTHER
14. Maiden Name Stella Polkavich
15. Birthplace Lith

16 (a) Informant Norbert Calliflower
(b) Address 1414 Eutaw Place

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan 25-47 (month) (day) (year)
(c) Cemetery or crematory Holy Redeemer
Location Beltsville Rd

18 (a) Funeral director Joseph Kasunskas
(b) Address 602 Washington Blvd

19 (a) (Date rec'd by registrar) (b) [illegible] Registrar

Jan 24, 1947 [illegible]

MEDICAL CERTIFICATION

20. DATE OF DEATH 1-20 1947, at 1:30 P M

21. I certify that I took charge of the remains described above, held an Autopsy thereon and from the evidence obtained (Autopsy, Inspection or Inquiry) by said Autopsy, Inspection or Inquiry, find that said deceased came to her death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☑, suicide ☑, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH suicide

Traumatic severance of trunk of body at brim of pelvis with evisceration of viscera

Due to

Other Conditions multiple fractures lacerations and bruises.
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 1-20-47 at 11:05 P M.
(b) Where did injury occur? Pumphrey + Balto. Highway
(c) Did injury occur at home, on farm, industrial place, in public place? public While at work? no
(d) Means of injury Struck by train

23. Signature Howard J. Madeira M.D.
Medical Examiner.
Date signed 1-22-47

VS 15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

107 00121

Reg. Dist. No. 21

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Be correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Enroute to Hospital

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 3 Months

Hospital, institution, or street address where death occurred: Enroute to Hospital

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Anne Arundel

City or town: Parole Md. near Annapolis

(If outside city or town limits, write RURAL and give nearest town)

Street No.: Parole Maryland

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Michael Craig Connor

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colored	

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): September 21, 1946

8. AGE:

Years	Months	Days	If less than one day
0	3	16	..... hrs. ..... min.

9. Birthplace: Parole Maryland (Town, county, and state)

10. Usual occupation: None

11. Industry or business: None

FATHER

12. Name: Charles Connor

13. Birthplace: Baltimore Maryland

MOTHER

14. Maiden name: Erma Larkins

15. Birthplace: Parole Maryland

16. Informant: Erma Larkins

Address: Parole Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof 1-8- 1947 (month) (day) (year)

Cemetery or crematory: Brewer Hill

Location: West Street Extended

18. Funeral director: Mrs. Charles E. Hicks

Address: 43-45 Northwest Street

19. Jan. 8, 1947 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 1-5 1947, at 5:15 P M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Jan 3 1947, to Jan 5 1947

and that I last saw him alive on Jan 5 1947

Immediate cause of death: Bronchial Pneumonia — DURATION

Due to:

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: A. T. Allen MD M. D. or other

Address: 1-7 Conduit St. Date signed 1-6-47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

926 00122

Reg. Dist. No. 21

PLEASE WRITE PLAINLY, WITH NON-FADING INK. Supply every item of information carefully. Use correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County Anne Arundel

City or town Annapolis (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred: Emergency Hospital

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State Maryland County Anne Arundel

City or town Defense Highway (If outside city or town limits, write RURAL and give nearest town)

Street No. (If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Grace Wingert Coover

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife Charles H. Coover

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 20th 1888

8. AGE: Years 59 | Months 10 | Days 5 | If less than one day hrs. min.

9. Birthplace Franklin Co Penn. (Town, county, and state)

10. Usual occupation House wife.

11. Industry or business

FATHER 12. Name Abraham L. Wingert

13. Birthplace Franklin Co Penn

MOTHER 14. Maiden name Mary E. Garman

15. Birthplace Franklin Co. Penn.

16. Informant Mr Chas H. Coover

Address Defense Highway Gaa Co Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Jany. 28, 1947 (month) (day) (year)

Cemetery or crematory Cedar Grove

Location Chambersburg, Penn.

18. Funeral director John M. Taylor Son

Address Annapolis Md.

19. Jan. 26, 1947 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 25 1947, at 7.52 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 15 1946, to Jan 5 1947

and that I last saw h.er alive on Jan 25 1947

Immediate cause of death	DURATION
uremia	8 hrs
Due to chron: parenchymatous nephritis,	
arteriosclerosis	
Due to mitral insufficiency &	3 mos.
decompensation	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE I. Brooks M.D. M. D. or other

Address Annapolis Md Date signed 1/27/47

1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

00123

Reg. Dist. No. 27

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Jessup

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 35 days

Hospital, Institution, or street address where death occurred:

How long in hospital or Institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Anne Arundel

City or town: Jessup, Md.

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Charles Lee Davis

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widowed

6.(b) Name of husband or wife: Mary Ellen Davis

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): January 15, 1864

8. AGE: Years	Months	Days	If less than one day
83	0	13	6 hrs. ..... min.

9. Birthplace: Baltimore, Md.
(Town, county, and state)

10. Usual occupation: Retired

11. Industry or business

FATHER 12. Name: Charles H. Davis

FATHER 13. Birthplace: Baltimore, Md.

MOTHER 14. Maiden name: Caroline Fritz

MOTHER 15. Birthplace: Baltimore, Md.

16. Informant: Laura L. Wright

Address: Jessup, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 1/30/47 (month) (day) (year)

Cemetery or crematory: Parkwood

Location: Baltimore

18. Funeral director: Leonard J. Ruck

Address: 5305 Stafford Road

19. Jan 29 1947 (Date rec'd by registrar) P. W. Hedrick Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Jan. 28 1947, at 6:10 A.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Dec. 24 1946, to Jan. 28 1947

and that I last saw him alive on Jan. 27 1947

Immediate cause of death	DURATION
Auricular fibrillation	1 day
Chronic myocarditis	Years
Due to: Arteriosclerosis, general	20 yrs
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: John A. Clark M.D.
M. D. or other

Address: Jessup Md Date signed 1/28/47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 006128

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Crownsville State Hospital
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 5 months 1 day
Hospital, institution, or street address where death occurred:
Crownsville State Hospital, Crownsville, Md.
How long in hospital or institution? 5 months 1 day

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Baltimore City
City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 920 Shields Place
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Davis - Evelyn Tasker

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Negro	Married

6.(b) Name of husband or wife: Sylvester Davis (Husband)
6.(c) If alive, give age: ? years

7. Birth date of deceased (mo., day, yr.): 1918

8. AGE: Years	Months	Days	If less than one day
28	?	?	...hrs. ...min.

9. Birthplace: Maryland
(Town, county, and state)

10. Usual occupation: Housework

11. Industry or business: ?

FATHER
12. Name: John Tasker
13. Birthplace: Maryland

MOTHER
14. Maiden name: Isobel (Adams) Tasker
15. Birthplace: Maryland

16. Informant: Hospital Records Crownsville State
Address: Hospital, Crownsville, Maryland

17. Bury (Burial, cremation, or removal. Which?) Date thereof: January 22, 1947 (month) (day) (year)
Cemetery or crematory: Mt. Auburn
Location: Baltimore City, Maryland

18. Funeral director: George G. Kelson
Address: 1303 Pressman Street

19. 1/21/47 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: January 19, 1947, at 12:05 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from August 18, 1944, to January 19, 1947, and that I last saw her alive on January 19, 1947.

Immediate cause of death: Tuberculosis of Lungs — DURATION: Known to us since Dec 5 1946

Due to:

Due to:

Other conditions: Schizophrenia — DURATION: Known to us since Aug. 18 1944

(Include pregnancy within 3 months of death)

Major findings of operations: ... Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ... Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: [signature] M. D. or other
Address: Crownsville State Hospital Date signed: 1/20/47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

157a

00125

Reg. Dist. No. 23

1. PLACE OF DEATH:

County: Anne Arundel.

City or town: Glen Burnie

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? two minutes.

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland. County: Talbot.

City or town: Royal Oak

(If outside city or town limits, write RURAL and give nearest town)

Street No.: 1

(If rural, give LOCATION)

2.(a) If veteran, name war: ✓

3. (a) FULL NAME: Donald Russell Dube Jr.

3. (b) Social Security Number: NONE

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M.	W.	Single

6.(b) Name of husband or wife: —

6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): October 17 - 1946

8. AGE:

Years	Months	Days	If less than one day
	2	23	..... hrs. ..... min.

9. Birthplace: Easton Memorial Hosp. County (Town, county, and state)

10. Usual occupation: None.

11. Industry or business

FATHER

12. Name: Donald Russell Dube Sr.

13. Birthplace: Somerset, Mass.

MOTHER

14. Maiden name: Patricia Thompson

15. Birthplace: Washington, D. C.

16. Informant: Mrs. Donald R. Dube, Sr.

Address: Royal Oak, Md.

17. Ship- (Burial, cremation, or removal. Which?) Date thereof: Jan 11 - 1947 (month) (day) (year)

Cemetery or crematory: P.R.R.-N.Y.N.H. & H. to Providence R.I

Location: Hearse to Fall River Mass

18. Funeral director: Homer W. Dunstan

Address: Glen Burnie, Md.

19. Jan. 11 1947 (Date rec'd by registrar) M. Dedrick Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: January 10 1947 at 6:20 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....

and that I last saw h..... alive on ..... 19.....

	DURATION
Immediate cause of death: Convulsions due to hydrocephaly.	2 days
Due to:	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results: .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: Gustave A. Faulenbach M.D.

Address: Glen Burnie, Md. Date signed 1/10/47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correctness is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

162a

00126

Reg. Dist. No. 21

1. PLACE OF DEATH:

County Anne Arundel

City or town Rural, Annapolis Neck

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Anne Arundel

City or town Annapolis Neck Md

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Burlie N. Duncan

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	Colored	married

6.(b) Name of husband or wife Maggie J. Duncan

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) July 3, 1879

8. AGE: Years	Months	Days	If less than one day
67	5	29	..... hrs. ..... min.

9. Birthplace Lancaster S. C.
(Town, county, and state)

10. Usual occupation Laborer

11. Industry or business

FATHER 12. Name Wilson Duncan

13. Birthplace S. C.

MOTHER 14. Maiden name Martha Jones

15. Birthplace S. C.

16. Informant Bernard Duncan

Address 116 South St. Annapolis Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Jan 6 1947 (month) (day) (year)

Cemetery or crematory Brewer Hill

Location Annapolis Md.

18. Funeral director J.B. Johnson

Address Annapolis Md

19. Jan. 4 1947 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 2 1947 at 1420 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 12-46 19.. to 1-2 19.47

and that I last saw h.. alive on 12-2 19..46

Immediate cause of death Starvation — DURATION

Due to Senile Dementia

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE G. T. Allen M.D. M. D. or other

Address 17 Carroll St Date signed 1-3-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

516 * 00127

Reg. Dist. No. 210

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Iglehart's

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:

How long in hospital or Institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Anne Arundel

City or town: Annapolis

(If outside city or town limits, write RURAL and give nearest town)

Street No. 103 Prince Geo

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: William H. Freeman

3.(b) Social Security Number: 214-05-6668 A

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widow

6.(b) Name of husband or wife: Ida E. Freeman

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): June 24th 1879

8. AGE: Years: 67 Months: 7 Days: 4 If less than one day: ..... hrs. ..... min.

9. Birthplace: Annapolis Md (Town, county, and state)

10. Usual occupation: Engineer

11. Industry or business: Annapolis Dairy

FATHER — 12. Name: William Freeman

13. Birthplace: Annapolis Md.

MOTHER — 14. Maiden name: Rebecca Jones

15. Birthplace: A A Co Md.

16. Informant: Norman R. Freeman

Address: Iglehart's A A Co Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Jan 31st 1947 (month) (day) (year)

Cemetery or crematory: Cedar Ridge

Location: Annapolis Md

18. Funeral director: John M. Taylor & Son

Address: Annapolis Md

19. Jan. 29 1947 (Date rec'd by registrar) ..... Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Jan 28 1947 at 3 27 P M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Jan 22 1947 to Jan 28 1947 and that I last saw h... alive on Jan 28 1947

Immediate cause of death	DURATION
Carcinoma of prostate & metastases to lung & brain	3 mos (?)
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) ..... (County) ..... (State)

Injured at home, farm, Industry, public place (where?)

Means of injury ..... Injured at work?

23. SIGNATURE: S. Bozzuto M.D. M. D. or other

Address: Annapolis Md Date signed: 1/29/47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Be correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

131 b * 00128

CERTIFICATE OF DEATH

Reg. Diat. No. 20

1. PLACE OF DEATH:

County A.A.

City or town Davidsonville
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 37 Years

Hospital, Institution, or street address where death occurred:
Davidsonville

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County A.A.

City or town Davidsonville,
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Peter Gaug. Sr.

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	Widowed

6.(b) Name of husband or wife Margarett Gaug. 6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov 4 1860

8. AGE: Years	Months	Days	If less than one day
86	2	12	hrs. min.

9. Birthplace Austria (Town, county, and state)

10. Usual occupation Farmer

11. Industry or business

FATHER — 12. Name Unknown

13. Birthplace Unknown

MOTHER — 14. Maiden name Unknown

15. Birthplace Unknown

16. Informant Anton Gaug

Address Davidsonville, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Jan 18 1947 (month) (day) (year)

Cemetery or crematory St. Marys

Location Annapolis, Md.

18. Funeral director B.L.Hopping & Son

Address Annapolis, Md.

19. Jan 17, 1947 (Date rec'd by registrar) 1-23 Carrie Smith Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 16th 1947 at 2.30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb 1946 to Jan 16th 1947 and that I last saw him alive on Jan 16th 1947

Immediate cause of death		DURATION
	Pneumonia	
Due to	Circulatory failure	6 Y
Due to	Chronic nephritis	
Other conditions		

(Include pregnancy within 3 months of death)

Major findings of operations Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, Industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Edith Roeder, M.D. M. D. or other

Address 42 State Circle Annapolis Date signed 1-16-47

VS A15 9-45.15M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

2-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

97 00129

Reg. Dist. No. 28

1. PLACE OF DEATH: Anne Arundel County
County Crownsville State Hospital
City or town Crownsville, Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 16 yrs. 6 mos. 5 days
Hospital, institution, or street address where death occurred:
Crownsville State Hospital, Crownsville, Md.
How long in hospital or institution? 16 yrs. 6 mos. 5 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Queen Anne Co. County ?
City or town ?
(If outside city or town limits, write RURAL and give nearest town)
Street No. ?
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME
Mary Gibson

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Negro	Widow

6.(b) Name of husband or wife --
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) 1869 (?)

8. AGE: Years	Months	Days	If less than one day
77 (?)	?	?	..... hrs. ..... min.

9. Birthplace Maryland
(Town, county, and state)

10. Usual occupation Housewife

11. Industry or business

FATHER
12. Name Thomas Goldborough
13. Birthplace Maryland

MOTHER
14. Maiden name Annie Smith
15. Birthplace Maryland

16. Informant Hospital Reocrds, Crownsville State
Address Hospital, Crownsville, Maryland

17. Burial
(Burial, cremation, or removal. Which?)
Date thereof 2-5-47
(month) (day) (year)

Cemetery or crematory Crownsville Hospital Cemetary
Location Crownsville, Maryland

18. Funeral director Sexton
Address Crownsville

19. 2/5/47 19.....
(Date rec'd by registrar)
E. Joyce Local
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH January 27 1947, at 2:45 AM

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from July 22, 1930, to January 27 1947
and that I last saw her alive on January 26 1947

Immediate cause of death: Generalized Arteriosclerosis — DURATION: Known to us since July 22, 1930

Due to:

Due to:

Other conditions: Senile Psychosis

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE Albert V. Hustead
M. D. or other
Address Crownsville, Maryland Date signed 1/27/47

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

00130

Reg. Dist. No. 201

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Brandish
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Md. County: Anne Arundel

City or town: Brandish
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Lana Lin Giles

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	Col	Sin

B.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Nov 29 1946

8. AGE: Years | Months 2 | Days 1 | If less than one day ..... hrs. 2 hrs ..... min.

9. Birthplace Brandish
(Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER 12. Name Noel Giles

13. Birthplace [illegible]

MOTHER 14. Maiden name [illegible]

15. Birthplace [illegible]

16. Informant Noel Giles

Address [illegible]

17. Burial (Burial, cremation, or removal. Which?) Date thereof Jan 31 1947 (month) (day) (year)

Cemetery or crematory Brandish Elm

Location Brandish

18. Funeral director E. E. Hambleton & Son

Address Galesville Md

19. 1/31 (Date rec'd by registrar) 19 47 W. M. Clayton Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 1/30/47, at 5:A M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from 1/29 19 ..... to 1/30/47 19 .....

and that I last saw h... alive on 1/29 19 .....

Immediate cause of death	DURATION
Pulmonary Embolism	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE [illegible] M. D. or other

Address [illegible] Date signed 1/31/47

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

46b

00131

Reg. Dist. No. 21

1. PLACE OF DEATH:
County: Anne Arundel Co.
City or town: Annapolis
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Life
Hospital, institution, or street address where death occurred: 22 Northwest Street
How long in hospital or institution? ----------

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Anne Arundel
City or town: Annapolis
(If outside city or town limits, write RURAL and give nearest town)
Street No. 22 Northwest Street
(If rural, give LOCATION)
2.(a) If veteran, name war ----------

3.(a) FULL NAME: Bertie Beatrice Grant

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Colored	Married

6.(b) Name of husband or wife: James Grant

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): March 12, 1898

8. AGE: Years	Months	Days	If less than one day
48	10	13	..... hrs. ..... min.

9. Birthplace: Annapolis Maryland (Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business: None

FATHER
12. Name: Thomas Kimble
13. Birthplace: Annapolis Maryland

MOTHER
14. Maiden name: Katie Blackstone
15. Birthplace: Annapolis Maryland

16. Informant: Maggie Wilson
Address: 22 Northwest Street

17. Burial (Burial, cremation, or removal. Which?) Date thereof 1-29-1947 (month) (day) (year)
Cemetery or crematory: Brewer Hill
Location: West Street Extended

18. Funeral director: Mrs. Charles E. Hicks
Address: 43-45 Northwest Street

19. Jan. 29 1947 (Date rec'd by registrar) [signature] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: January 25, 1947, at 11:40 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 8/10 1946, to 1/25 1947 and that I last saw her alive on Jan 25 1947

Immediate cause of death	DURATION
Carcinoma of Stomach	1 yr.
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results: .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE: Theodore G. Johnson M. D. M. D. or other
Address: 40 Northwest Street Date signed: 1/28/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

164 a

00132

CERTIFICATE OF DEATH

Reg. Dist. No. 220

1. PLACE OF DEATH:
County: Anne Arundel.
City or town: Homeland Park, RD. Hanover
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 5 years.
Hospital, institution, or street address where death occurred: Elkridge Landing Road.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: A. A.
City or town: Hanover.
(If outside city or town limits, write RURAL and give nearest town)
Street No. Elkridge Landing Road.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Frederick C. H. Keube

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M.	W.	Widowed.

6.(b) Name of husband or wife: Agnes Miller
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): October 9 - 1864

8. AGE:

Years	Months	Days	If less than one day
82	2	24	hrs. min.

9. Birthplace: Germany
(Town, county, and state)
10. Usual occupation: machinist.
11. Industry or business

FATHER
12. Name: Unknown
13. Birthplace: Germany.

MOTHER
14. Maiden name: Unknown
15. Birthplace: Germany

16. Informant: Mrs. Elizabeth Keube
Address: Hanover, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 1-7-1947 (month) (day) (year)
Cemetery or crematory: Cedar Hill
Location: A. A. Co. Md.

18. Funeral director: Flynn & Fleming
Address: 1426 Light St.

19. 1/6 1947 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: January 3 1947 at 4 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 19 to 19
and that I last saw h alive on 19

Immediate cause of death	DURATION
Strangulation	
(Hanging himself in chicken Coop.)	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Suicide Date of 1/3/47
Where did injury occur? Hanover, A. A. / Md.
(City or town) (County) (State)
Injured at home, farm, industry, public place (where?) Chicken House
Means of injury Hanging Injured at work? No

23. SIGNATURE: Conrad D. Fowler M.D.
Acting Medical Examiner M. D. or other
Address Glen Burnie, Md. Date signed 1/3/47

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 26

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County: Anne Arundel County

City or town: Crownsville, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 11 months 5 days

Hospital, institution, or street address where death occurred:
Crownsville State Hospital

How long in hospital or institution? 11 months 5 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County:

City or town: Baltimore City
(If outside city or town limits, write RURAL and give nearest town)

Street No.:
(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME

H auser - Lilly A.

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Negro	Married

6.(b) Name of husband or wife: William Hauser

6.(c) If alive, give age: Unknown years

7. Birth date of deceased (mo., day, yr.): 1897

8. AGE: Years	Months	Days	If less than one day
50	Unknown	Unknown	hrs. ---- min.

9. Birthplace: Baltimore, Md.
(Town, county, and state)

10. Usual occupation: Housework

11. Industry or business:

FATHER
12. Name: Peter Fryer
13. Birthplace: South Carolina

MOTHER
14. Maiden name: Margaret Green
15. Birthplace: South Carolina

16. Informant: Hospital Records
Address: Crownsville, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof Jan. 12, 1947 (month) (day) (year)

Cemetery or crematory: Mt. Calvary

Location: Anne Arundel

18. Funeral director: James A. Hayes

Address: 142 West Hill St. Baltimore, Md.

19. 1-13-47 (Date rec'd by registrar) [signature] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: January 9 1947 19..., at 4:10 P M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from February 15 19 46, to January 9 19 47 and that I last saw h.er alive on January 9 19 47

Immediate cause of death: Cerebral Hemorrhage — DURATION: Known to us since Feb. 15 1945

Due to: General Paresis

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE [signature] M. D. or other

Address: Crownsville, Maryland Date signed Jan. 10, '47

Maryland State

~~BALTIMORE CITY~~ HEALTH DEPARTMENT

CERTIFICATE OF DEATH 1314

Registered No. 27

1. PLACE OF DEATH:
(a) ~~Baltimore City~~, Maryland Queenstown Anne R.D. Severn Arundel County Md.
(b) Street address
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in ~~Baltimore~~ Queenstown (yrs., mos., or days) 15 years

2. USUAL RESIDENCE OF DECEASED:
(a) State Maryland (b) County Anne Arun
(c) City or town Queenstown
(If outside city or town limits, write RURAL and give town)
(d) Street No. Post office Severn Md
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME William Hayes

3 (b) If veteran, name war	3 (c) Social Security Account No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	Col.	married.

6 (b) Name of husband or wife Alexina Hayes
6 (c) If alive, give age 62 years

7. Birth date of deceased (mo., day, yr.) Feb-15-1873

8. AGE: Years	Months	Days	If less than one day
73	10	20	hr. min.

9. Birthplace Town unknown, Maryland
(Town, county, and state)
10. Usual Occupation Farmer
11. Industry or business

FATHER
12. Name unknown
13. Birthplace unknown

MOTHER
14. Maiden Name unknown
15. Birthplace unknown

16 (a) Informant Mrs. Alexina Hayes
(b) Address Queenstown, Md.

17 (a) Burial (b) Date thereof 1-8-47
(Burial, cremation, or removal) (month) (day) (year)
(c) Cemetery or crematory Fairview Cem
Location Ca-Ce. Co. Md.

18 (a) Funeral director James A Hayes
(b) Address 142 W. 41st St.

19 (a) 1/6/47 (b) H.D. Hedrick M.D.
(Date received by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH January - 5 - 19 47 at 10 45 A.M.

21. I certify that death occurred on the date above stated; that I attended deceased from October 19 47 to Jan - 4 - 19 47, and that I last saw him alive on Jan - 14 - 19 47.

Immediate cause of death Congestive heart failure
Due to Bright disease of kidneys
Due to Chronic glomerulonephritis 10/22/47 as.
Other Conditions

(Include pregnancy within 3 months of death)

Date of operation
Major findings of operation:
of autopsy:

Duration

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence at M
(c) Where did injury occur?
(City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? While at work?
(Specify type of place)
(e) Means of injury

23. Signature Walther H. Sonnenfeldt M. D.
Address 2708 Hollins Ferry Rd Baltimore, 30, Md. Date signed 1/5/47.

VS 150

1-35

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

I MARGIN RESERVED FOR BINDING

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

94a

00135

Reg. Dist. No. 28

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Crownsville State Hospital
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 7 months 13 days

Hospital, Institution, or street address where death occurred:
Crownsville State Hospital Crownsville, Md.

How long in hospital or institution? 7 months 13 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Baltimore City

City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)

Street No.: ?
(If rural, give LOCATION)

2.(a) If veteran, name war: ✓

3.(a) FULL NAME

Haynes - Mamie

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Negro	Married

6.(b) Name of husband or wife: Walter Haynes

6.(c) If alive, give age: ? years

7. Birth date of deceased (mo., day, yr.): ? 1874

8. AGE: Years	Months	Days	If less than one day
73 (?)	?	?	...hrs. ...min.

9. Birthplace: Maryland
(Town, county, and state)

10. Usual occupation: R

11. Industry or business: ?

FATHER
12. Name: ?
13. Birthplace: ?

MOTHER
14. Maiden name: ?
15. Birthplace: ?

16. Informant: Hospital Records, Crownsville State
Address: Hospital, Crownsville, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof 1-5-47 (month) (day) (year)

Cemetery or crematory: Hospital Cemetary

Location: Crownsville, Maryland

18. Funeral director: Burial
Address: Crownsville

19. 1/5/47 19... E. Joyce Local (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: January 19 1947 at 4:25 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 6 1941 to January 19 1947 and that I last saw her alive on January 19 1947

Immediate cause of death: Coronary Occlusion — DURATION: 1 day

Due to: Advanced Arteriosclerosis — Known to us since June 6, 1941

Due to:

Other conditions: Senile Psychosis; depressed type — Known to us since June 6, 1941
(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: [signature] M. D. or other

Address: Crownsville, Maryland Date signed: Jan. 19, 1947

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

83a

00136

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH:

County Anne Arundel

City or town Annapolis

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Anne Arundel

City or town Annapolis

(If outside city or town limits, write RURAL and give nearest town)

Street No. 72 Clay

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Elizabeth Hebron

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	colored	Single

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) March 1, 1876

8. AGE: Years	Months	Days	If less than one day
57	10	3	..... hrs. ..... min.

9. Birthplace Prince George Co Md.
(Town, county, and state)

10. Usual occupation Domestic

11. Industry or business

FATHER 12. Name Samuel Hebron

13. Birthplace Md.

MOTHER 14. Maiden name Catherine Hebron

15. Birthplace Md.

16. Informant Elizabeth Watkins

Address 72 Clay St Annapolis Md

17. Burial

(Burial, cremation, or removal. Which?) Date thereof Jan. 10 1947
(month) (day) (year)

Cemetery or crematory Bowen Hill

Location Annapolis Co. Md.

18. Funeral director J. B. Duncan

Address Annapolis Md.

19. Jan. 8, 1947

(Date rec'd by registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH January 4, 1947, at 5:10 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....

and that I last saw h..... alive on ..... 19.....

Immediate cause of death	DURATION
Cerebral Apoplexy	8 days
Due to Patient Selerotic Hypertension	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury ..... Injured at work?

23. SIGNATURE R. C. Buchanan M.D.
M. D. or other

Address Annapolis Md. Date signed 1/8/47

VS A15 9-45-15M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

00137

932

CERTIFICATE OF DEATH

Reg. Dist. No. 25

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County A A County

City or town Brooklyn Hts

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md County A A Co

City or town Brooklyn Hts

(If outside city or town limits, write RURAL and give nearest town)

Street No. 5319 Patuxent Beach Drive

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Walter Hugh Heider

3.(b) Social Security Number —

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M.	W	Married

6.(b) Name of husband or wife Nan C. Heider

6.(c) If alive, give age 55 years

7. Birth date of deceased (mo., day, yr.) Sept 5 1875

8. AGE: Years	Months	Days	If less than one day
71	—	-	hrs. min.

9. Birthplace Kentucky (Town, county, and state)

10. Usual occupation Retired Salesman

11. Industry or business Self

FATHER 12. Name Unknown

13. Birthplace "

MOTHER 14. Maiden name Unknown

15. Birthplace "

16. Informant Nancy C. Heider wife

Address 3024 S Hoover Ave Balt.

17. Cremation (Burial, cremation, or removal, Which?) Date thereof Jan 16 47 (month) (day) (year)

Cemetery or crematory London Park Cem

Location Frederick Rd

18. Funeral director Fulton Schilling

Address 3914 Hanover St

19. Jan 15 1947 (Date rec'd by registrar) Ida M. Whitten Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 13 1947 at 7.45 A M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Dec 22 1946 to Jan 13 1947

and that I last saw him alive on Jan 13 1947

	DURATION
Immediate cause of death Coronary thrombosis	
Due to Hypertension with cardiovascular disease	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE B. V. Keister MD M. D. or other

Address 302 Talbot Co Date signed 1/13/47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

00138

CERTIFICATE OF DEATH

Reg. Dist. No. 28

Anne Arundel

1. PLACE OF DEATH:

County Crownsville State Hospital

City or town Crownsville, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 3 years 3 months 16 days

Hospital, Institution, or street address where death occurred:
Crownsville State Hospital

How long in hospital or institution? 3 years 3 months 16 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County

City or town Baltimore
(If outside city or town limits, write RURAL and give nearest town)

Street No. 729 School St.
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Henson - Sherman James

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Negro	Single

6.(b) Name of husband or wife -

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo. day. yr.) 1906 - June 22

8. AGE: Years	Months	Days	If less than one day
40	7	0	..... hrs. ..... min.

9. Birthplace Maryland
(Town, county, and state)

10. Usual occupation Laborer

11. Industry or business ?

FATHER
12. Name James Henson
13. Birthplace ?

MOTHER
14. Maiden name Abbie Gorden
15. Birthplace ?

16. Informant Hospital Records, Crownsville State
Address Hospital, Crownsville, Maryland

17. Buried (Burial, cremation, or removal. Which?) Date thereof Jan. 25, 1947 (month) (day) (year)

Cemetery or crematory Mt. Auburn

Location Baltimore City

18. Funeral director Geo. G. Kelson

Address 1303 Presstman Street

19. Jan. 24 1947 (Date rec'd by registrar) A. W. Hedrick Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH January 22, 1947, at 11:00 A.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from October 4 1944, to January 22 1947

and that I last saw him alive on January 22 1947

	DURATION
Immediate cause of death General Paresis	
Due to General Paresis	Known to us since 10/4/44
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Herbert J. Brantcade M. D. or other

Address Crownsville, Maryland Date signed 1/22/47

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

93 b ★ 00139

Reg. Diat. No. 210

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Annapolis Md.

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred: Emergency Hospital

How long in hospital or institution? 5

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Anne Arundel

City or town: Arnold Md.

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Henry Hirsch

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Margaret Ditzel Hirsch

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): July 7th 1877

8. AGE: Years	Months	Days	If less than one day
69	6	15	hrs. min.

9. Birthplace: Baltimore Md. (Town, county, and state)

10. Usual occupation: Farmer

11. Industry or business

FATHER 12. Name: Unknown

13. Birthplace: Unknown

MOTHER 14. Maiden name: Unknown

15. Birthplace: Unknown

16. Informant: Mrs Henry Hirsch

Address: Arnold Md. R.F.D.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Jany 26th 1947 (month) (day) (year)

Cemetery or crematory: St Margarets

Location: St Margarets A.A.Co. Md.

18. Funeral director: Ogle Bell Taylor Son

Address: Annapolis Md.

19. Jan. 23 1947 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Jan 22 1947, at 9P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 15 1946, to Jan 22 1947 and that I last saw h[illegible] alive on Jan 22 1947

Immediate cause of death	DURATION
Myocarditis & Myocardial Insufficiency Ch.	Unknown
Due to	
Due to	
Other conditions Arteriosclerosis	Unknown

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: Geo C Beal M. D. or other

Address: Annapolis Md Date signed 1-23-47

1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

00140

CERTIFICATE OF DEATH

Reg. Dist. No. 21

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Annapolis Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred: Emergency Hospital
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Anne Arundel
City or town: Woodlawn Beach
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Richard Lee Hollar

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife: none
6.(c) If wife, give age ... years

7. Birth date of deceased (mo., day, yr.): Dec 12th 1946

8. AGE: Years	Months	Days	If less than one day
	1	13	hrs. ... min.

9. Birthplace: Annapolis Md.
(Town, county, and state)
10. Usual occupation: none
11. Industry or business

FATHER
12. Name: Joseph B. Hollar
13. Birthplace: Mt Jackson Va

MOTHER
14. Maiden name: Lucille Lanham
15. Birthplace: Lincoln Va

16. Informant: Joseph B. Hollar
Address: Woodlawn Beach A A Co Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Jany 27th 1947 (month) (day) (year)
Cemetery or crematory: Cedar Blvd
Location: Annapolis Md.
18. Funeral director: John M. Taylor Son
Address: Annapolis Md.

19. Jan. 26, 1947 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: January 25 1947, at Jan 26 M 47
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 25, 1947, to Jan 26 1947
and that I last saw him alive on Jan 26, 1947

Immediate cause of death	DURATION
Burns - Pneumonia	3 days
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide. Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: Albert L. Anderson M.D.
M. D. or other
Address: Annapolis Md. Date signed 1/26/47

1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

53

00141

CERTIFICATE OF DEATH

Reg. Diat. No. 201

1. PLACE OF DEATH
County: Anne Arundel
City or town: Sudley
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 10 yrs 9 days.
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Anne Arundel
City or town: Sudley
(If outside city or town limits, write RURAL and give nearest town)
Street No.: R.F.D.
(If rural, give LOCATION)
2.(a) If veteran, name war: no

3.(a) FULL NAME: Charles Henry Howard

3.(b) Social Security Number: no

4. Sex: male
5. Color or race: white
6.(a) Single, married, widowed, or divorced: widowed
6.(b) Name of husband or wife: dead Jessie S. Weir
6.(c) If alive, give age ..... years
7. Birth date of deceased (mo., day, yr.): 1869
8. AGE: Years: 78 Months: Days: If less than one day: ..... hrs. ..... min.
9. Birthplace: Harwood Md (Town, county, and state)
10. Usual occupation: Farmer
11. Industry or business:
FATHER 12. Name: Wm Henry Howard
13. Birthplace: Unknown
MOTHER 14. Maiden name: Eliza Hayson
15. Birthplace: Unknown
16. Informant: Gordan Howard
Address: Sudley
17. Burial (Burial, cremation, or removal. Which?) Date thereof: Jan 11 1947 (month) (day) (year)
Cemetery or crematory: Howard Cem on farm
Location: Sudley Md
18. Funeral director: T. A. Haubrich & Son
Address: Galesville Md
19. 1/11 1947 (Date rec'd by registrar) M. Clayton Dep Reg Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Jany 9 1947 at 7 45 P.M

21. I CERTIFY that death occurred on the date above stated ~~Mr. Underdetermined~~ Postmortem Examination Jany 9 1947

	DURATION
Immediate cause of death: Carcinoma of face	unknown
Due to:	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results: .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE: John M. Claffy M.D. Deputy Medical Examiner
M. D. or other
Address: Annapolis Md Date signed 1/11/47

VS A15 9-45-15M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

00142

93d

Reg. Diat. No. 210

1. PLACE OF DEATH:
County Anne Arundel
City or town Ferry Farm Nr Annapolis
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Anne Arundel
City or town Ferry Farm
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Edith Powell Howard

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widow

6.(b) Name of husband or wife Edwin T. Howard
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Sept 21st 1861

8. AGE: Years	Months	Days	If less than one day
85	3	14	..... hrs. ..... min.

9. Birthplace St Louis Mo
(Town, county, and state)

10. Usual occupation none

11. Industry or business

FATHER
12. Name John C. Powell
13. Birthplace St Louis Mo

MOTHER
14. Maiden name Emma Webster
15. Birthplace St Louis Mo

16. Informant Mrs. J. H. Cunningham
Address White Hall Jefferson Va

17. Removal
(Burial, cremation, or removal. Which?)
Date thereof Jan 7th 1947
(month) (day) (year)

Cemetery or crematory
Location St. Louis Mo.

18. Funeral director John M. Taylor Son
Address Annapolis Md.

19. Jan 7 1947
(Date rec'd by registrar)
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 5 1947, at 5P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 1940, to Jan 5 1947
and that I last saw h[illegible] alive on Jan 5 1947

Immediate cause of death Myocardial Infarction, CHD — DURATION 7 yrs

Due to

Due to

Other conditions Arteriosclerosis — DURATION unknown

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.

Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Gage C Powell M. D. or other
Address Annapolis Md Date signed 1-6-47

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1-25

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

932 00143

Reg. Dist. No. 250

1. PLACE OF DEATH:

County A. A. County

City or town Brooklyn Park Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 20 yrs

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Md County A. A. County

City or town Brooklyn Park -25-
(If outside city or town limits, write RURAL and give nearest town)

Street No. 317 Arundel Road
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME James Frederick Irwin

3. (b) Social Security Number 219-12-6113

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife

6.(c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.) June 4th - 1882

8. AGE: Years 64 | Months | Days | If less than one day ____ hrs. ____ min.

9. Birthplace Baltimore Md
(Town, county, and state)

10. Usual occupation Black Smith

11. Industry or business

FATHER 12. Name Thomas F Irwin

13. Birthplace Baltimore Md

MOTHER 14. Maiden name Mary Marlin

15. Birthplace Anne Arundel County

16. Informant Mr. Thomas W. Irwin

Address 3700 S. Third St -25-

17. Burial (Burial, cremation, or removal. Which?) Date thereof Jan 31-47 (month) (day) (year)

Cemetery or crematory Cedar Hill Cemetery

Location Gov. Ritchie Highway

18. Funeral director Milton Schilling

Address 3914 Hanover St.

19. Jan 29 1947 (Date rec'd by registrar) Ida M. Whelan Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH January 28th 1947, at 12.30 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 27 1947, to Jan 29 1947 and that I last saw h alive on Jan 27 1947.

Immediate cause of death	DURATION
Cerebral Hemorrhage	
Due to Hypertension	
Coffitis-vascular	
Due to Senesce	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Samuel Rubin M. D. or other

Address 203 Dalapla Ave Date signed

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

87a

00144

Reg. Dist. No. 21

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Skidmore, Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Anne Arundel
City or town: Skidmore R. 2.
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME: James A. Johnson

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colored	married

6.(b) Name of husband or wife: Nancy Johnson
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Feb. 1, 1892

8. AGE: Years	Months	Days	If less than one day: hrs.	min.
54	10			

9. Birthplace: Skidmore A. A. Co. (Town, county, and state)
10. Usual occupation: Laborer
11. Industry or business
FATHER — 12. Name: Alfred Johnson
13. Birthplace: Va.
MOTHER — 14. Maiden name: Julia Berry
15. Birthplace: Va.
16. Informant: Nancy Johnson
Address: R2 Box 547 Annapolis Md
17. Burial (Burial, cremation, or removal. Which?) Date thereof: Jan. 5, 1947 (month) (day) (year)
Cemetery or crematory: Broadneck
Location: Skidmore, Md.
18. Funeral director: J. B. Johnson
Address: Annapolis Md.
19. Jan. 4, 1947 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION 47

20. DATE OF DEATH: Jan 1, 1947, at 12:15 A M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct 1, 1946, to Jan 1, 1947 and that I last saw him alive on Dec 20, 1946

Immediate cause of death	DURATION
Undetermined - Probably Multiple Sclerosis	3 mos.
Due to: Sudden onset of pain in R. hip & Fever	
Due to: followed by progressive Paralysis of both lower extremities	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide. Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: M. J. Klavans M.D. M. D. or other
Address: 31 Southgate Ave. Date signed: 1/3/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

83a

00145

CERTIFICATE OF DEATH

Reg. Diat. No. 210

1. PLACE OF DEATH:

County Anne Arundel

City or town Annapolis Md.

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

State House

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Anne Arundel

City or town Annapolis Md

(If outside city or town limits, write RURAL and give nearest town)

Street No. 108 Charles St.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Edward B. Jones

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widower

6.(b) Name of husband or wife Mary Jones

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Feby 16th 1865

8. AGE:	Years	Months	Days	If less than one day
	81	10	17	..... hrs. ..... min.

9. Birthplace Annapolis Md.
(Town, county, and state)

10. Usual occupation Ret. Painter + Paper Hanger

11. Industry or business

FATHER 12. Name William Jones

13. Birthplace C & A Co Md.

MOTHER 14. Maiden name Unknown

15. Birthplace Unknown

16. Informant William Jones

Address 108 Charles St Annapolis Md

17. Burial Date thereof Jany 5th 1946
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Cedar Bluff

Location Annapolis Md

18. Funeral director John M. Taylor, Son

Address Annapolis Md

19. Jan 5 1947
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jany. 2 1947 at 10 15 A M

21. I CERTIFY ~~that death occurred on the date above stated; that I attended deceased from~~ Post Mortem Examination

~~and that I last saw h... alive on~~ Jany. 2 1947

Immediate cause of death

	DURATION
Cerebral Hemorrhage	sudden
Due to General arterio Sclerosis	unknown
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operation ..... Date of op. .....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE John M. Caffey M.D. Deputy Medical Examiner
M. D. or other

Address Annapolis Md Date signed 1-4-47

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Be correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 932

CERTIFICATE OF DEATH

00146

Reg. Dist. No. 201

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County Frederick

City or town Near

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md County Fr

City or town Frederick Rte 4

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Lou Jones

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	S

6.(b) Name of husband or wife —

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) 1872

8. AGE: Years	Months	Days	If less than one day
74			..... hrs. ..... min.

9. Birthplace ..... (Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER 12. Name Wm Jones

13. Birthplace Va

MOTHER 14. Maiden name Mary Jones

15. Birthplace Va

16. Informant Mrs. M. Clusty

Address Frederick Md

17. Burial Date thereof 1/11/47

(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory

Location Bridgewater Va

18. Funeral director W. A. Hutchins

Address Owings Md.

19. Jan 8 1947 Chas L Hutchins

(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 1/8 1947, at 8 a.m. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 1940 to Jan 8 1947 and that I last saw h alive on Jan 5 1947

	DURATION
Immediate cause of death Arteriosclerosis	5 yrs
Due to Chronic myocarditis	2 yrs
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE H Hunsaker M. D. or other

Address Owings Md Date signed 1/8/47

2-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 97

CERTIFICATE OF DEATH

00147

Reg. Dist. No. 28

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Use correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH: A.A County

County Crownsville State Hospital

City or town Crownsville, Maryland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 6 yrs. 11 mos. 3 wks. 10 days

Hospital, Institution, or street address where death occurred:

Crownsville State Hospital, Crownsville, Md.

How long in hospital or institution? 6 yrs. 11 mos. 3 wks. 10 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County ?

City or town ?

(If outside city or town limits, write RURAL and give nearest town)

Street No. ?

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME JONES - MARSHALL

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Negro	Separated

6.(b) Name of husband or wife ?

6.(c) If alive, give age ? years

7. Birth date of deceased (mo., day, yr.) 1876

8. AGE: Years	Months	Days	If less than one day
70 (?)	?	?	....hrs. ....min.

9. Birthplace Maryland (Town, county, and state)

10. Usual occupation Handy Man

11. Industry or business ---

FATHER 12. Name Joseph Jones

13. Birthplace Maryland

MOTHER 14. Maiden name Julia Foreman

15. Birthplace Maryland

16. Informant Hospital Records Crownsville State

Address Hospital, Crownsville, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof ---- (month) (day) (year)

Cemetery or crematory Hospital Cemetary

Location Crownsville, Maryland

18. Undertaker Sexton Supt Hospital

Address Crownsville Md

19. 2/6/47 19.... E T Joyce (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH January 30 1947 at 6:20 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Febuary 7 1940 to January 30 1947 and that I last saw h.im alive on January 29 1947

Immediate cause of death	DURATION
General Arteriosclerosis	Known to us since Feb. 7, 1940
Due to	
Due to	
Other conditions Senile Psychosis	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Albert V. Strickland M. D. or other

Address Date signed

1-25

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

01047

Reg. Dist. No. 200

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Mayo
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 10 years
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Anne Arundel
City or town: Mayo
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war: none

3.(a) FULL NAME: Samuel B. Jones

3.(b) Social Security Number: 218-03-6916

4. Sex: Male
5. Color or race: Col.
6.(a) Single, married, widowed, or divorced:

6.(b) Name of husband or wife: Queenie Jones
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Mar 16. 1910

8. AGE: Years: 36 | Months: 10 | Days: 13 | If less than one day: hrs. min.

9. Birthplace: Mayo (town, county, and state)

10. Usual occupation: Oysterman

11. Industry or business

FATHER
12. Name: Samuel Jones
13. Birthplace: Unknown

MOTHER
14. Maiden name: Queenie Brown
15. Birthplace: Mayo

18. Informant: Queenie Brown
Address: Mayo

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Jan 13 1947 (month) (day) (year)
Cemetery or crematory: Mayo Colm
Location: Mayo.

18. Funeral director: F. C. Stoltzfus & Son
Address: Galesville Md.

19. Jan 12 19 47 Edward Collem Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Jan 9 1947 at ? P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct 6 1946 to Jan 9 1947 and that I last saw him alive on Jan 8 1947

Immediate cause of death	DURATION
Pulmonary Tuberculosis	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Emily H. Wilson M. D. or other
Address: Galesville, Md. Date signed: 1/11/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

V. S. No. 1

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

STATE OF MARYLAND—CERTIFICATE OF DEATH

00148

46b

1. PLACE OF DEATH

County A. A. ~~Baltimore~~ (AMS= Book 1/16/47) Registration Dist. No.

Village or City Brooklyn No. 920 E. Church St., Ward

(If death occurred in a hospital or institution, give its NAME instead of street and number)

Length of residence in city or town where death occurred ____ yrs. ____ mos. ____ ds. How long in U.S. If of foreign birth? ____ yrs. ____ mos. ____ ds.

2. FULL NAME Louis Kalivodasr If U. S. Veteran, specify WAR

(a) Residence: No. 920 E. Church St., Ward.

(Usual place of abode) If nonresident give city or town and State

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word)
male	white	married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Mary (nee Soustek)

6. DATE OF BIRTH (month, day, and year) August 13, 1884

7. AGE Years	Months	Days	If LESS than 1 day, ___ hrs. or ___ min.
62			

OCCUPATION

8. Trade, profession, or particular kind of work done, as SPINNER, SAWYER, BOOKKEEPER, etc. retired

9. Industry or business in which work was done, as SILK MILL, SAW MILL, BANK, etc.

10. Date deceased last worked at this occupation (month and year)

11. Total time (years) spent in this occupation

12. BIRTHPLACE (city or town) (State or country) Czechoslovakia

FATHER

13. NAME Joseph Kalivodasr

14. BIRTHPLACE (city or town) (State or country) Czechoslovakia

MOTHER

15. MAIDEN NAME Unknown

16. BIRTHPLACE (city or town) (State or country) "

17. INFORMANT Mrs. Mary Soustek Kalivodasr

(Address) 920 E. Church Street

18. BURIAL, ~~CREMATION, OR REMOVAL~~

Place Cedar Hill Cem. Date 1/15/ 1947

19. UNDERTAKER Charles E. Schimunek

(Address) 2601 E. Madison St. Baltimore, Md

FILED JAN 16 1947 19 Huntington Williams M.D. Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH January 12, 1947

(Month) (Day) (Year)

22. I HEREBY CERTIFY, That I attended deceased from December 2, 1946, to January 12, 1947

I last saw him alive on Jan. 10, 1947, death is said to have occurred on the date stated above, at 5:30 A.m.

The PRINCIPAL CAUSE OF DEATH and related causes of importance were as follows:

Cause	Date of onset
Carcinoma of Stomach	9 mo.

Other Contributory Causes of Importance:

Name of operation Date of

What test confirmed diagnosis? Was there an autopsy? no

23. If death was due to external causes (VIOLENCE) fill in also the following:

Accident, suicide, or homicide? Date of injury , 19

Where did injury occur?

(Specify city or town, county and State)

Specify whether injury occurred in INDUSTRY, in HOME, or in PUBLIC PLACE.

Manner of injury

Nature of injury

24. Was disease or injury in any way related to occupation of deceased? no

If so, specify

(Signed) R. J. Emmald M.D. M. D.

(Address) 4409 Ft. Ritchie Hwy

If more blanks are needed, address State Registrar, 2411 N. Charles Street, Baltimore, Requesting V. S. No. 1.

1-35

UNITED STATES STANDARD CERTIFICATE OF DEATH

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the deceased had retired from business, report the occupation prior to retirement. Children not gainfully employed may be returned as **at school** or **at home**. For a woman whose only occupation was that of home housework, write **housewife** in answer to Question 8 and **own home** in answer to Question 9. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as **servant—private family, cook—hotel**, etc. For a person who had no occupation whatever write **none**.

To be complete, an occupation return must state:

8.—The trade, profession, or particular kind of work done.
9.—The industry or business in which the work was done.
10.—The month and year the deceased last worked at the occupation.
11.—The number of years the deceased followed the occupation.

In stating the occupation, avoid the use of such indefinite terms as "employee," "worker," "operative," etc. Find out the particular kind of work done and return that, as **spinner, weaver**, etc.

In stating the industry or business, avoid the use of such general terms as "store," "factory," "mill," etc. State the particular kind of store, factory, mill, etc., as **grocery store, soap factory, cotton mill**, etc.

Distinguish carefully the different kinds of engineers by stating the full descriptive titles, as **civil engineer, mechanical engineer, mining engineer, stationary engineer**, etc. Avoid the term "laborer" when a more precise statement of the occupation can be secured. Do not use the word "mechanic," but give the exact occupation, as **carpenter, painter, machinist**, etc. Distinguish carefully between **retail merchants** and **wholesale merchants**. A person who sells goods should be called a **salesman** and not a **clerk**.

Statement of cause of death.—Cause of death means the disease, injury, or complication which causes death, not the mode of dying, e. g., heart failure, asphyxia, asthenia, etc. As principal cause name the disease or injury causing death. As related causes, name earlier morbid conditions, if any, related to the principal cause and any important complication of the principal cause. Under other contributory causes of importance, name other important diseases or injuries. Examples:

Example I		Example II	
The principal cause of death and related causes of importance were as follows:	Date of onset	The principal cause of death and related causes of importance were as follows:	Date of onset
Arteriosclerosis	*1915*	*Attack of epilepsy*	*1 week ago*
Chronic interstitial nephritis	*1921*	*Run over by street car*	*1 week ago*
Cerebral hemorrhage	*July 5, 1927*	*Peritonitis*	*3 days ago*
Other contributory causes of importance:		Other contributory causes of importance:	
Gallstones	*May 1, 1923*	*Gastroenteritis*	*1 year*

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

00149

Reg. Dist. No. 25

1. PLACE OF DEATH:
County: AA County
City or town: Clean Water Beach Md
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 7 mos
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md County: A A County
City or town: Clean Water Beach Md
(If outside city or town limits, write RURAL and give nearest town)
Street No.: Parkway Road
(If rural, give LOCATION)
2.(a) If veteran, name war:

3. (a) FULL NAME: Josephine Kanowoske

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed.

6.(b) Name of husband or wife: Hyacet Kanowoske
6.(c) If alive, give age: years
7. Birth date of deceased (mo., day, yr.): Jan 23 - 1869

8. AGE:

Years	Months	Days	If less than one day
77	—	—	hrs. min.

9. Birthplace: Poland (Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business:

FATHER
12. Name: M. Kanowoske
13. Birthplace: Poland

MOTHER
14. Maiden name: M. Konopka
15. Birthplace: Poland

16. Informant: Mrs Chas Evans
Address: Clean Water Beach Md Co PO

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Jan 14 47 (month) (day) (year)
Cemetery or crematory: Holy Cross Cem
Location: Gov Ritchie Highway
18. Funeral director: Milton Litchfield
Address: 3914 Hanover St - Balto

19. Jan 13 1947 (Date rec'd by registrar) Ida M. Whitson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Jan 11th 1947 at 12.04 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 12/16/46 19.. to 1/11/47 19.. and that I last saw h.. alive on 1/9/47 19..

Immediate cause of death	DURATION
Due to: Concussion of Stomach	About 2 yrs
Due to:	
Other conditions	

(include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: John F Alexander MD
M. D. or other
Address: Glen Burnie Date signed: 1/11/1947

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

932

00150 21

Reg. Dist. No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County AN ARUNDEL

City or town GLEN BURNIE (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 24 YRS

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State MARYLAND County AN ARUNDEL

City or town GLEN BURNIE (If outside city or town limits, write RURAL and give nearest town)

Street No. 119 S. 5TH AVE (If rural, give LOCATION)

2.(a) If veteran, name war NO

3.(a) FULL NAME ANNA KLAMPEN

3.(b) Social Security Number NONE

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	WIDOW

6.(b) Name of husband or wife BERNHART KLAMPEN 6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) DEC 12 1868

8. AGE: Years	Months	Days	If less than one day
78	1	5	..... hrs. ..... min.

9. Birthplace BALTIMORE MD. (Town, county, and state)

10. Usual occupation HOUSEWIFE

11. Industry or business At Home

FATHER 12. Name Unknown

FATHER 13. Birthplace Md.

MOTHER 14. Maiden name JULIA REITZ

MOTHER 15. Birthplace MARYLAND

16. Informant VIRGIE SEEBO

Address GLEN BURNIE, MD.

17. Removal (Burial, cremation, or removal, Which?) Date thereof 1/18/47 (month) (day) (year)

Cemetery or crematory Pheobus

Location Va

18. Funeral director William Cook Inc.

Address 1217 St. Paul St.

19. 1/18 19 47 (Date rec'd by registrar) A. W. Hedrick Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan. 17 1947 at 5 a. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan. 1947 to Jan 17 1947 and that I last saw h alive on Jan. 14 1947

Immediate cause of death	DURATION
Cerebral Hemorrhage	Immediate
Due to Arteriosclerosis & Cardio-vascular Disease	5 yrs
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations None

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE James S. Buckingham M.D. M. D. or other

Address Glen Burnie Md Date signed Jan 17, 1947

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

94a * 00151

CERTIFICATE OF DEATH

Reg. Dist. No. 21

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Jones Station, Severna Park, Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 55 Years

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Anne Arundel

City or town: Jones Station (Severna Park P.O
(If outside city or town limits, write RURAL and give nearest town)

Street No.: Dividing Creek Road
(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: THOMAS H. LANGLEY

3.(b) Social Security Number: NONE

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widdower

B.(b) Name of husband or wife: Cecelia Langley

8.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): May 30, 1867.

8. AGE: Years	Months	Days	If less than one day
79	7	14	..... hrs. ..... min.

9. Birthplace: Baltimore
(Town, county, and state)

10. Usual occupation: Retired lineman

11. Industry or business:

FATHER
12. Name: William Henry Langley
13. Birthplace: Baltimore, Md.

MOTHER
14. Maiden name: Cornelia Galloway
15. Birthplace: Baltimore, Md.

16. Informant: Thomas H. Langley Jr.
Address: Jones Station Severna Park, P.O.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Jan. 17 1947 (month) (day) (year)

Cemetery or crematory: Langley's Private Cemetery

Location: Jones Station Md.

18. Funeral director: Thomas W. Singleton

Address: Glen Burnie, Md.

19. Jan 17 1947 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: January 14 1947, at 10.30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 12/30/46 19.. to 1/14/47 19..

and that I last saw h... alive on 1/13/47 19..

Immediate cause of death	DURATION
Due to: Coronary Thrombosis	
Due to:	Unknown
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results: .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: [signature] M. D. or other

Address: Glen Burnie, Md. Date signed: 1/14/47

1-55

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

00152 8

83a

CERTIFICATE OF DEATH

Reg. Dist. No. 25

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Brooklyn Pk

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County: A. A. Co.

City or town: Brooklyn Pk

(If outside city or town limits, write RURAL and give nearest town)

Street No. 100 W. 2nd Ave.

(If rural, give LOCATION)

2.(a) If veteran, name war: No

3.(a) FULL NAME: Annie A. Larkin

3.(b) Social Security Number: No

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Single

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Jan 10, 1873

8. AGE:

Years	Months	Days	If less than one day
73	11	25	..... hrs. ..... min.

9. Birthplace: Balto Md

(Town, county, and state)

10. Usual occupation: at home

11. Industry or business

MOTHER FATHER

12. Name: Dont know

13. Birthplace: Dont know

14. Maiden name: Dont know

15. Birthplace: Dont know

16. Informant: Edward B. Larkin

Address: 100 W. 2nd Ave.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Jan 8, 1947 (month) (day) (year)

Cemetery or crematory: Holy Cross

Location: A. A. Co.

18. Funeral director: A. Howard Evans

Address: 1402 St Charles St

19. 1/6/47 (Date rec'd by registrar) 19..... A. W. Hedrick Registrar

85

MEDICAL CERTIFICATION

20. DATE OF DEATH: Jan. 5, 1947, at 10:10 a. M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from June 10 1946, to Jan 5 1947

and that I last saw h[illegible] alive on Jan 5 1947

Immediate cause of death	DURATION
Cerebral Hemorrhage	2 Ds.
Due to: Arteriosclerosis	6 mos.
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results: .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: — Date of —

Where did injury occur? — (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: ..... Injured at work?

23. SIGNATURE: R. E. L. Campbell M. D. or other

Address: 104 Hanover St Date signed: 1/6/47

VS A15 9-45-15M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

00153

MARYLAND STATE DEPARTMENT OF HEALTH

241 W. Charles St., Baltimore

CERTIFICATE OF DEATH

85

Reg. Dist. No. 28

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Crownsville, Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? since July 31, 1937
Hospital, institution, or street address where death occurred:
Crownsville State Hospital
How long in hospital or institution? since July 31, 1937

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Anne Arundel
City or town: Crownsville, State Hospital
(If outside city or town limits, write RURAL and give nearest town)
Street No.: Crownsville, Maryland
(If rural, give LOCATION)
2.(a) If veteran, name war: ----

3. (a) FULL NAME: Earl Laws

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Black	Single

6.(b) Name of husband or wife: ----
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Sept 15, 1920

8. AGE: Years	Months	Days	If less than one day
26			..... hrs. ..... min.

9. Birthplace: Baltimore md
(Town, county, and state)

10. Usual occupation: none

11. Industry or business: none

FATHER
12. Name: Abe Laws
13. Birthplace: Va

MOTHER
14. Maiden name: Emma Laws
15. Birthplace: Va

16. Informant: Emma Laws
Address: 929 W Franklin St

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Jan 9 47 (month) (day) (year)
Cemetery or crematory: Mt Calvary
Location: A. A. Co. Md

18. Funeral director: Isaiah Bryant & Son
Address: 108 W. Montgomery St.

19. 1-9-47 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: January 6 1947 at 5:55 AM

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from July 31 1937 to January 6, 47 and that I last saw him alive on January 5, 47

Immediate cause of death: Status epilepticus — DURATION

Due to: congenital epilepsy

Due to:

Other conditions: spastic idiocy

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results: .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: No Date of .....
Where did injury occur? None (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE: [signature] M. D. or other
Address: Crownsville State Hospital Date signed: 1/6/47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Incorrect age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 00154 23

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:
County Anne Arundel
City or town Hernsdale
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? About 6 weeks –
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md. County
City or town Baltimore (30)
(If outside city or town limits, write RURAL and give nearest town)
Street No. 1406 Hull St –
(If rural, give LOCATION)
2.(a) If veteran, name war ✓

3.(a) FULL NAME John Leineweber

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widower

6.(b) Name of husband or wife Anna Catherine Leineweber (nee Burger) 6.(c) If alive, give age – years

7. Birth date of deceased (mo., day, yr.) May ?, 1866

8. AGE: Years 80 | Months 7 | Days ? | If less than one day ... hrs. ... min.

9. Birthplace Kassel, Germany
(Town, county, and state)

10. Usual occupation Retired Longshoreman (15 yrs)

11. Industry or business

MOTHER FATHER
12. Name Don't Know
13. Birthplace Germany –
14. Maiden name Don't Know
15. Birthplace Germany

16. Informant Charles A. Leineweber (Son)
Address No. 8 Hernsdale Ave, Hernsdale, Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof Jan. 21, 1947 (month) (day) (year)
Cemetery or crematory Mt. Olivet Cemetery
Location Baltimore, Md.

18. Funeral director A. Howard Evans
Address 1400 E. Charles St, Balto. 2, Md.

19. 1-20 1947 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH January 18, 1947 at 12:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 8 1947 to Jan 18 1947 and that I last saw him alive on Jan 17 1947

Immediate cause of death

		DURATION
Due to	Cerebral Hemorrhage	1 day
Due to	Chronic Interstitial nephritis.	
Due to	Cause Endocarditis	
	Certain Senility	

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE John [illegible] M. D. or other
Address [illegible] Date signed 1/18/47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

H69

00155

Reg. Dist. No. 2.1

1. PLACE OF DEATH:
County Anne Arundel
City or town Annapolis Md
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Anne Arundel
City or town Annapolis Md.
(If outside city or town limits, write RURAL and give nearest town)
Street No. 118 Gloucester St.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Peter H. Magruder

3.(b) Social Security Number

4. Sex: Male
5. Color or race: White
6.(a) Single, married, widowed, or divorced: Single
6.(b) Name of husband or wife: Single
6.(c) If alive, give age ..... years
7. Birth date of deceased (mo., day, yr.): Dec 28th 1871
8. AGE: Years 75 Months 0 Days 12 If less than one day ..... hrs. ..... min.
9. Birthplace Annapolis Md (Town, county, and state)
10. Usual occupation Retired. Secty
11. Industry or business Naval Academy Annapolis
12. FATHER Name John Read Magruder
13. Birthplace Annapolis Md.
14. MOTHER Maiden name Emily Nicholson
15. Birthplace Annapolis Md
16. Informant Papers left by deceased
Address Annapolis Md
17. Burial (Burial, cremation, or removal. Which?) Date thereof Jany 8th 1947 (month) (day) (year)
Cemetery or crematory St Anns
Location Annapolis Md
18. Funeral director John M Taylor Son
Address Annapolis Md.
19. January 7, 1947 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 6 Jan 1947 at 6:00 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 1946 to 6 Jan 1947 and that I last saw h[illegible] alive on 6 Jan 47 19..

Immediate cause of death	DURATION
Circulatory failure	1 day
Due to Neoplastic disease of biliary tract (Diagnosis made on clinical finding and progress. Operation and autopsy refused.)	5 mos.
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations None In all probability patient had recurrence of the Date of op. 10/22/46

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following.
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Donald H. Hooker, M. D.
Address 53 Cornhill St. Annapolis, Md. M. D. or other
Date signed 7 Jan 47

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH INDELIBLE INK. Supply every item of information carefully. Give correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

00156

Reg. Diat. No. 230

1. PLACE OF DEATH:

County: Anne Arundel

City or town: North Linthicum

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Few Hours

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County:

City or town: Baltimore

(If outside city or town limits, write RURAL and give nearest town)

Street No.: 1748 S. Charles St.

(If rural, give LOCATION)

2.(a) If veteran, name war: World War 11

3.(a) FULL NAME: SALVADORE A. MARCELLINO

3.(b) Social Security Number: 214 20 3591

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): December 21, 1924

8. AGE: Years	Months	Days	If less than one day
22	0	9	hrs. min.

9. Birthplace: Baltimore Md. (Town, county, and state)

10. Usual occupation: Tool Makers Helper

11. Industry or business: Maryland Drydocks

FATHER 12. Name: Joseph Marcellino

13. Birthplace: Termio Italy.

MOTHER 14. Maiden name: Providence Russo

15. Birthplace: Termio, Italy

16. Informant: Mr. Joseph Marcellino

Address: 1748 S. Charles Street, Balto. Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: 1 - 4 - 47 (month) (day) (year)

Cemetery or crematory: Most Holy Redeemer

Location: Baltimore, Md.

19. Funeral director: James L. McCauley

Address: 180 E. Fort Ave.

19. Jan 3 19 46 (Date rec'd by registrar) C. W. Hahn Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: January 1 1947 at About 6.00 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....

and that I last saw h..... alive on ..... 19.....

Immediate cause of death	DURATION
cerebral hemorrhage	
(Ruptured running Aneurism)	Sudden
Due to: Fracture of skull	Sudden
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, ~~suicide, or homicide~~ accident Date of 1/1/47

Where did injury occur? N. Linthicum a.c. (City or town) (County) Md. (State)

Injured at home, farm, industry, public place (where?) "Frank's home."

Means of injury Fell down stairway. Injured at work? No

23. SIGNATURE: Gustave H. Faucher M.D.

acting medical examiner M. D. or other

Address: Glen Burnie, Md. Date signed 1/1/47

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

00157

Reg. Dist. No. 280

1. PLACE OF DEATH:
County Anne Arundel
City or town Gambrills (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 45 years
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)
State Maryland County A. A.
City or town Gambrills (If outside city or town limits, write RURAL and give nearest town)
Street No. (If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Mrs. Harietta Hooper McKernan

3.(b) Social Security Number

4. Sex F.
5. Color or race W.
6.(a) Single, married, widowed, or divorced Widow
6.(b) Name of husband or wife Charles H. McKernan Sr.
6.(c) If alive, give age — years
7. Birth date of deceased (mo., day, yr.) June 5th 1878
8. AGE: Years 68 Months 7 Days 0 If less than one day ... hrs. ... min.
9. Birthplace Pittsburg – Penn. (Town, county, and state)
10. Usual occupation Housewife
11. Industry or business
FATHER 12. Name George T. Turnbaugh
13. Birthplace Maryland
MOTHER 14. Maiden name Emma C. Matthews
15. Birthplace Maryland
16. Informant Mr. Ro. V. McKernan
Address 5507 – [illegible] Ave – Balt. 7.
17. Burial (Burial, cremation, or removal. Which?) Date thereof Jan 31/47 (month) (day) (year)
Cemetery or crematory Baldwin Memorial
Location Millersville – Md.
18. Funeral director B. L. Hopkins & Son
Address Annapolis, Md.
19. 1/29.47 (Date rec'd by registrar) E. J. Joyce Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH January 28 1947, at 10.45 P. M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from August 1945, to Jan. 28 1947, and that I last saw her alive on January 28 1947.

	DURATION
Immediate cause of death Cerebral Hemorrhage	3 days
Due to Hypertension	
Due to	
Other conditions (Include pregnancy within 3 months of death)	

Major findings of operations ... Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ... Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury ... Injured at work?

23. SIGNATURE Gustav H. Fankerts M.D. M. D. or other
Address Glen Burnie Md. Date signed 1/29/47

1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

97 * 00158

Reg. Dist. No. 28

1. PLACE OF DEATH: A.A. County
County Crownsville State Hospital
City or town Crownsville, Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 17 months 2 days
Hospital, institution, or street address where death occurred:
Crownsville State Hospital
How long in hospital or institution? 17 months 2 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County ?
City or town ?
(If outside city or town limits, write RURAL and give nearest town)
Street No. ?
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME
Morris - Custis

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Negro	Married

6.(b) Name of husband or wife ?
6.(c) If alive, give age ? years

7. Birth date of deceased (mo., day, yr.) ? 1867

8. AGE: Years	Months	Days	If less than one day
80 (?)	?	?	...hrs. ...min.

9. Birthplace Virginia (?)
(Town, county, and state)

10. Usual occupation Farmer

11. Industry or business ?

MOTHER FATHER
12. Name John Morris
13. Birthplace Virginia
14. Maiden name Eliza ?
15. Birthplace Virginia

16. Informant Hospital Records Crownsville State
Address Hospital, Crownsville, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof 2-5-47 (month) (day) (year)
Cemetery or crematory Hospital Cemetary
Location Crownsville, Maryland

18. Funeral director Dept. of Correction Md
Address

19. 2/5 47 (Date rec'd by registrar) E. Joyce Doane Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH January 23, 1947 at 3:32 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from August 21, 1945 to January 23, 1947 and that I last saw him alive on January 22 1947

Immediate cause of death General Arteriosclerosis — DURATION: Known to us since August 21 1945

Due to

Due to

Other conditions Senile Psychosis — Known to us since 8/21/45
(Include pregnancy within 3 months of death)

Major findings of operations — Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide — Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury — Injured at work?

23. SIGNATURE [signature] M. D. or other
Address Crownsville, Maryland Date signed 1/23/47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

103 — 00159 — Reg. Dist. No. 21

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly. — MARGIN RESERVED FOR BINDING — VS A15

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Marley Heights - P.O. Glen Burnie
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 6 years.
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: A-A.
City or town: P.O. Glen Burnie,
(If outside city or town limits, write RURAL and give nearest town)
Street No.: Marley Heights.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: SARAH JANE - NORWOOD

3.(b) Social Security Number: 0

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W.	Widow

6.(b) Name of husband or wife: William Henry Norwood.
6.(c) If alive, give age: Dead years

7. Birth date of deceased (mo., day, yr.): March - 7 - 1864

8. AGE:

Years	Months	Days	If less than one day
82	8	25	hrs. min.

9. Birthplace: Fairmount, Maryland.
(Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business

FATHER
12. Name: George Layfield
13. Birthplace: Maryland

MOTHER
14. Maiden name: Mary A. Ford
15. Birthplace: Maryland.

16. Informant: Mrs. Wm. David Norwood,
Address: Marley Heights, P.O. Glen Burnie

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Jan 6-47 (month) (day) (year)
Cemetery or crematory: Fairmount M E Cemetery
Location: Fairmount Md.

18. Funeral director: Bernard A Fink
Address: 3603 Belair Rd.

19. Jan. 4 1947 (Date rec'd by registrar) A. W. Hedrick Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: January 3rd 1947, at 5 A. M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from ... 19... to ... 19...
and that I last saw h...alive on ... 19...

Immediate cause of death	DURATION
Cerebral hemorrhage	
Due to: Senility	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ... Date of op. ...
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ... Date of ...
Where did injury occur? ... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) ...
Means of injury ... Injured at work?

23. SIGNATURE: Gustave A Rauber M.D. Acting Medical Examiner M. D. or other
Address: Glen Burnie, Md. Date signed: 1/3/47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

93d

00160

Reg. Dist. No. 216

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH: Anne Arundel
County
City or town: Annapolis
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Life
Hospital, institution, or street address where death occurred: 122 South Street
How long in hospital or institution? ---

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Anne Arundel
City or town: Annapolis
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 122 South Street
(If rural, give LOCATION)
2.(a) If veteran, name war: ---

3.(a) FULL NAME: Mary Elizabeth Parker

3.(b) Social Security Number: ---

4. Sex: Female
5. Color or race: Colored
6.(a) Single, married, widowed, or divorced: Widowed

6.(b) Name of husband or wife: Allen Parker
6.(c) If alive, give age ... years

7. Birth date of deceased (mo., day, yr.): 1860

8. AGE: 86 Years | Months | Days | If less than one day ... hrs. ... min.

9. Birthplace: West River Maryland
(Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business: None

FATHER
12. Name: David Lee
13. Birthplace: Unknown

MOTHER
14. Maiden name: Eliza Franklin
15. Birthplace: Unknown

16. Informant: Lillie Parker
Address: 122 South Street

17. Burial (Burial, cremation, or removal. Which?) Date thereof 2-2-1947 (month) (day) (year)
Cemetery or crematory: Brewer Hill
Location: West Street Extended

18. Funeral director: Mrs. Charles E. Hicks
Address: 43-45 Northwest Street

19. Feb. 2, 1947 (Date rec'd by registrar) [signature] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Jan 29 1947, at 7-55 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb 9/46 to Jan 29 1947
and that I last saw h-r alive on Jan 28 1947

	DURATION
Immediate cause of death: Cardio Vascular Failure	about 2 wks or more.
Due to: Cr. Arteriosclerosis	several yrs
Due to: Cr. Myocarditis	several yrs.
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ... Date of op ...

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ... Date of ...
Where did injury occur? ... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) ...
Means of injury ... Injured at work?

23. SIGNATURE: J. Oliver Purvis M. D. or other
Address: Humphries M.D. Date signed 1/31/47

1-25

00161

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Annapolis Md.

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred: Emergency Hospital

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Anne Arundel

City or town: Near Annapolis

(If outside city or town limits, write RURAL and give nearest town)

Street No.: Pen. Dennis Mount

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Maud Edelin Parks

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widow

6.(b) Name of husband or wife: Frederick P. Parks

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Feby 24th 1877

8. AGE:

Years	Months	Days	If less than one day
69	10	6	..... hrs. ..... min.

9. Birthplace: Alexander Va

(Town, county, and state)

10. Usual occupation: none

11. Industry or business

FATHER

12. Name: Thomas Jefferson Edelin

13. Birthplace: Va

MOTHER

14. Maiden name: Emma Barton

15. Birthplace: Lancaster Va

16. Informant: Mrs Irvin P. Hall

Address: Pen Dennis Mt. Annapolis Md

17. Disposition: Cremation (Burial, cremation, or removal, Which?) Date thereof: Jan 20 1947 (month) (day) (year)

Cemetery or crematory: Ft Lincoln

Location: Pri Geo Co Md.

18. Funeral director: John M. Taylor Son

Address: Annapolis Md

19. Jan. 20 1947 (Date rec'd by registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Jan 18 1947, at 11:30a M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov 25 1946, to Jan 18 1947

and that I last saw h... alive on Jan 18 1947

	DURATION
Immediate cause of death: Cerebral hemorrhage	9 days
Due to: Arteriosclerosis - cardio vascular disease & hypertension	10 yrs.
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operation: Date of op

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following.

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: S. Bozeuch M D

M. D. or other

Address: Annapolis Md Date signed: 1/19/47.

VS A15 9-45-15M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Use correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

00162

Reg. Dist. No. 22

1. PLACE OF DEATH:
County: Anne-Arundel
City or town: Odenton
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 24 Years
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Anne-Arundel
City or town: Odenton
(If outside city or town limits, write RURAL and give nearest town)
Street No.: Nevada Ave & 4th street
(If rural, give LOCATION)
2.(a) If veteran, name war: No

3.(a) FULL NAME: Willie Ellsworth Phelps

3.(b) Social Security Number: 217-14-0326

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Daisy Viola
6.(c) If alive, give age: 61 years

7. Birth date of deceased (mo., day, yr.): October 27 1882

8. AGE: Years	Months	Days	If less than one day
64	2	23	hrs. min.

9. Birthplace: Odenton - Anne-Arundel Maryland (Town, county, and state)
10. Usual occupation: Painter
11. Industry or business

FATHER
12. Name: Byron Phelps
13. Birthplace: Odenton - Anne-Arundel - Maryland

MOTHER
14. Maiden name: Ella Bentz
15. Birthplace: Baltimore Maryland

16. Informant: Daisy Viola Phelps
Address: Nevada Ave & 4th street - Odenton Md.

17. Burial (Burial, cremation, or removal, which?) Date thereof: Jan 24-1947 (month) (day) (year)
Cemetery or crematory: Nichols Memorial
Location: Odenton Md R.D. #1
18. Funeral director: The H. C. White Co. Inc.
Address: Laurel, Md.
19. Jan 23 1947 (Date rec'd by registrar) Clara Hadley Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: January 21 1947, at M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from January 4 1947, to January 21 1947 and that I last saw h. I m. alive on January 19 1947

Immediate cause of death	DURATION
Bronchopneumonia - Hypostatic	10 days
Due to: Rheumatoid Arthritis	18 Months
Due to:	
Other conditions: Generalized Arterio-sclerosis	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Edward J. Merritt M. D.
M. D. or other
Address: Gambrills Md Date signed: 21 Jan 47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

2-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 0012 23

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Odenton Md. R.F.D. (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 30 years

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Maryland County: Anne Arundel

City or town: Odenton Md. R.F.D. # 1 Box 138 (If outside city or town limits, write RURAL and give nearest town)

Street No. Old WP&A Right of way (If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Milton D. Routzahn

3.(b) Social Security Number: 220-16-8161

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Florence E. Routzahn Nee Bradey 6.(c) If alive, give age 60 years

7. Birth date of deceased (mo., day, yr.): December 25, 1881

8. AGE: Years	Months	Days	If less than one day
65	1	5	..... hrs. ..... min.

9. Birthplace: Dayton, Ohio. (Town, county, and state)

10. Usual occupation: Manager Post Exchange # 9

11. Industry or business: Fort Meade

FATHER 12. Name: Martin Routzahn

13. Birthplace: Frederick Co. Md.

MOTHER 14. Maiden name: Cornelia Poffenberger

15. Birthplace: Frederick Co. Md.

16. Informant: Mrs. Florence E. Routzahn

Address: Odenton, Md. R.F.D.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Feb. 3, 1947 (month) (day) (year)

Cemetery or crematory: Trinity Church yard

Location: Patuxent, Md.

18. Funeral director: Thomas W. Singleton

Address: Glen Burnie, Md.

19. Feb 1 1947 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: January 30 1947, at 1:30 P.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from January 29 1930, to January 30 1947 and that I last saw h. i.m. alive on January 30 1947

Immediate cause of death: Coronary Thrombosis — DURATION: 24 Hrs

Due to: Rheumatic Heart Disease — 10 yrs

Due to: Arterio sclerosis, Generalized

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: Edward J. Merritt M. D. (M. D. or other)

Address: Gambrills, Md. Date signed Feb 1 1947

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 21

00164

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully; the correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County: A. A. Co.

City or town: Greenland Beach

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County: A.

City or town: Baltimore

(If outside city or town limits, write RURAL and give nearest town)

Street No.: 400 E. Fort Ave.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME John B. Schmidt

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	divorced

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Sept 22, 1869

8. AGE:

Years	Months	Days	If less than one day
77			..... hrs. ..... min.

9. Birthplace: Maryland (Town, county, and state)

10. Usual occupation: Retired

11. Industry or business

MOTHER FATHER

12. Name: Unknown

13. Birthplace: Unknown

14. Maiden name: Unknown

15. Birthplace: Unknown

16. Informant: Louise M. Baker

Address: Greenland Beach, A.A. Co. Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 1/28/47 (month) (day) (year)

Cemetery or crematory: Baltimore

Location: E. End of North Ave

18. Funeral director: Thos F. Kenny Inc

Address: 515 Eight St.

19. 1/28 19 47 (Date rec'd by registrar) A. H. Hedrick per LEK Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 1/25/47 19 ..... at 7:10 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from November 1946 to Jan. 25 1947

and that I last saw h.. alive on January 24 1947

Immediate cause of death	DURATION
Heart Failure	
Due to: Arteriosclerotic Cardio Vascular Disease	10 yrs.
Due to: Myocarditis	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: J. Brady Smith M.D. (M. D. or other)

Address: Riviera Beach Md. Date signed 1/27/47

1942
77
69

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

189 * 00165

Reg. Dist. No. 220

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County A.A.

City or town Jessups

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:

Maryland House of Correction

How long in hospital or institution? 9 hours

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Baltimore

City or town Baltimore

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME James H. Smith

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	?

6.(b) Name of husband or wife Unknown

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) 1885

8. AGE: Years	Months	Days	If less than one day
62			..... hrs. ..... min.

9. Birthplace Not known

(Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER 12. Name Unknown

13. Birthplace Unknown

MOTHER 14. Maiden name Unknown

15. Birthplace Unknown

16. Informant Records of Md H of Correction

Address Jessup Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof Jan 22, 1947 (month) (day) (year)

Cemetery or crematory Cherry Hill

Location Jessup Md

18. Funeral director N. L. Coelius

Address Jessup Md

19. Jan 22 1947 (Date rec'd by registrar) Clara Kasluk Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH January 12, 1947 at 4:45 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 11 1947, to January 12 1947 and that I last saw him alive on January 12 1947

	DURATION
Immediate cause of death Exhaustion	6 days
Due to Starvation - due to actual privation of food	several weeks.
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations None

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide none Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE John A Craik MD M. D. or other

Address MHC Jessup Md Date signed Jan 12/47

2-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

164C

00166

CERTIFICATE OF DEATH

Reg. Dist. No. 210

1. PLACE OF DEATH

County: Anne Arundel

City or town: Lillery Bay

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(Ex. for born infants give residence of mother)

State: Maryland County: Frederick

City or town: Brunswick

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war: World War II

3.(a) FULL NAME Arlvert H. Smoot

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Divorced

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Dec. 14, 1909

8. AGE: Years	Months	Days	If less than one day: hrs.	min.
37	1	10		

9. Birthplace: Middletown, Penna

(Town, county, and state)

10. Usual occupation: welder

11. Industry or business

FATHER — 12. Name: John Edward Smoot

13. Birthplace: Harrenton, Virginia

MOTHER — 14. Maiden name: Anna Kline

15. Birthplace: Wardensville W. Virginia

16. Informant: Ortense Smoot

Address: Brunswick Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Jan 27, 1947 (month) (day) (year)

Cemetery or crematory: Pawn Heights

Location: Brunswick

18. Funeral director: Thomas D Singleton

Address: Glen Burnie, Md.

19. Jan. 25 1947 (Date rec'd by registrar) McDealba Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Jany 24 1947 at about 10 P M

21. I CERTIFY that death occurred on the date above stated: Post mortem Examination

Jany 25 1947

Immediate cause of death	DURATION
Suicide	
Due to: by Shot-gun	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Suicide Date of: 1/24/47

Where did injury occur? Lillery Bay (City or town) A.A. (County) Maryland (State)

Injured at home, farm, industry, public place (where?) farm

Means of injury: 16 gauge Shot Gun Injured at work? no

23. SIGNATURE: John M. Claffy, M.D. M. D. or Coroner

Address: Annapolis, Md Date signed: 1/25/47

Deputy Medical Examiner

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Give correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

2-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

00167

Reg. Dist. No. 21

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County A. A.

City or town Annapolis

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 26 Days

Hospital, Institution, or street address where death occurred:

33 West

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County A. A.

City or town Annapolis

(If outside city or town limits, write RURAL and give nearest town)

Street No. 33 West

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Abraham Snyder

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	married

6.(b) Name of husband or wife Wetaska Snyder

6.(c) If alive, give age 67 years

7. Birth date of deceased (mo., day, yr.) Dec 17 1875

8. AGE: Years	Months	Days	If less than one day
71	1		..... hrs. ..... min.

9. Birthplace Russia (Town, county, and state)

10. Usual occupation Retired

11. Industry or business Tailor

FATHER 12. Name Hyman Snyder

13. Birthplace Russia

MOTHER 14. Maiden name Unknown

15. Birthplace "

16. Informant Samuel Snyder

Address 33 West St Annapolis Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof Jan 19 47 (month) (day) (year)

Cemetery or crematory Asbury Street

Location Three mile oak

18. Funeral director C L Hopkins & Son

Address 170-172 West St Annapolis Md

19 Jan. 18 19 47 (Date rec'd by registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 17 19 47 at 7 45 a M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Jan 19 40, to Jan 17 19 47

and that I last saw h.. alive on Jan 16 19 47

Immediate cause of death Myocarditis (Chr) Pt. Hemiplegia — DURATION 7 yrs 2 days

Due to Arteriosclerosis — DURATION unk

Due to — DURATION

Other conditions Chr nephritis — DURATION several years

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Geo C Boyd M. D. or other

Address Annapolis Md Date signed 1-18-47

1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

160 c 00168

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH:

County: Anne Arundel.

City or town: Riva.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 6 hrs. 15 mins

Hospital, institution, or street address where death occurred:
Riva

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Anne Arundel.

City or town: Riva Ferndale
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Baby Boy Starlings

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	S

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Jan. 6, 1947

8. AGE: Years | Months | Days | If less than one day: 6 hrs. 15 min.

9. Birthplace: Riva. (Town, county, and state)

10. Usual occupation: new-born infant.

11. Industry or business

MOTHER / FATHER

12. Name: Robert Davidson.

13. Birthplace: Pennsylvania

14. Maiden name: Blanche Naomi Starlings.

15. Birthplace: Riva. Md.

16. Informant: Blanche Naomi Starlings

Address: Ferndale, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Jan 8/47 (month) (day) (year)

Cemetery or crematory: St. Mary's

Location: Annapolis Md.

18. Funeral director: C. L. Hopkins & Son

Address: 170-172 West St. Annapolis

19. January 8, 1947 (Date rec'd by registrar) Wm. Brooch Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: January 6th, 1947, at 9:30 P M

21. I CERTIFY that death occurred on the date above stated: ~~that I attended deceased from~~ 19... to 19...

and that I last saw h... alive on 19...

Immediate cause of death	DURATION
Cardiorespiratory failure	
Due to: Asphyxiation	
Due to: Aspiration of Amniotic fluid	
Other conditions: Premature baby - 28 wks gestation	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide. Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: Edward P. Ritetumir, M. D. M. D. or other

Address: 199 Gloucester St. Annapolis, Md. acting Date signed: Jan. 6, 1947

VS A15 9-45-15M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

136 — 00169 — 28

Reg. Dist. No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Crownsville State Hospital
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? January 27, 1944

Hospital, institution, or street address where death occurred:
Crownsville, Maryland

How long in hospital or institution? January 27, 1944

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Prince George's Co.

City or town: Hyatsville
(If outside city or town limits, write RURAL and give nearest town)

Street No.: ———
(If rural, give LOCATION)

2.(a) If veteran, name war: ———

3. (a) FULL NAME
Staten - Viola

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Negro	Married

6.(b) Name of husband or wife: husband dead

6.(c) If alive, give age: ——— years

7. Birth date of deceased (mo., day, yr.): Unknown 189[illegible]

8. AGE: Years	Months	Days	If less than one day
51		Unknown	——hrs. ——min.

9. Birthplace: Unknown
(Town, county, and state)

10. Usual occupation: Housework

11. Industry or business: ———

FATHER
12. Name: Frank Beverly Shankley
13. Birthplace: Unknown

MOTHER
14. Maiden name: Rose Riley
15. Birthplace: Unknown

16. Informant: Unknown
Address: ———

17. Burial (Burial, cremation, or removal. Which?) Date thereof 2-5-47 (month) (day) (year)

Cemetery or crematory: Hospital Cemetary

Location: Crownsville, Maryland

18. Funeral director: Supt.
Address: Crownsville

19. Feby 5 1947 (Date rec'd by registrar) E. J. Boyer Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: January 10, 1947 19— at 5:30 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 27 1944, to January 10 1947 and that I last saw her alive on January 10 1947

Immediate cause of death	DURATION
Tuberculosis of Lungs	Known to us since March 2, 1946
Due to	
Due to	
Other conditions: Schizophrenia (Include pregnancy within 3 months of death)	Known to us since Jan. 27, '44

Major findings of operations: —
Date of op. —

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: — Date of —

Where did injury occur? — (City or town) — (County) — (State)

Injured at home, farm, industry, public place (where?) —

Means of injury — Injured at work? —

23. SIGNATURE: Robert V. Shankey M. D. or other

Address: Crownsville, Maryland Date signed 1/10/47

1-35

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

Registered No. 2

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:
(a) ~~Baltimore City~~, Maryland Brooklyn
(b) Street address 106 Church St.
(c) Hospital or institution?

(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in Baltimore (yrs., mos., or days) Life

2. USUAL RESIDENCE OF DECEASED:
(a) State Md. (b) County Anne Arundel
(c) City or town ~~Brooklyn~~ (If outside city or town limits, write RURAL and give town)
(d) Street No. 106 Church St. (If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Ridgeway George Steger STEGER

3 (b) If veteran, name war —
3 (c) Social Security Account No. none

4. Sex male | 5. Color or race white | 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife Lucia Steger
6 (c) If alive, give age 51 years

7. Birth date of deceased (mo., day, yr.) May 12 1892

8. AGE: Years 54 | Months 8 | Days 2 | If less than one day ... hr. ... min.

9. Birthplace Baltimore Md (Town, county, and state)

10. Usual Occupation retired machinist
11. Industry or business U.S. Coast Guard

FATHER
12. Name Wm. A. Steger
13. Birthplace Baltimore Md

MOTHER
14. Maiden Name Martha F. Magruder
15. Birthplace Baltimore Md

16 (a) Informant Mrs. Lucia Steger
(b) Address 106 Church St

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan 17 1947 (month) (day) (year)
(c) Cemetery or crematory Holy Cross
Location Balto. Md.

18 (a) Funeral director Bertram Lore
(b) Address 2324 E. Chase St.

19 (a) 1/14/47 (Date rec'd by registrar) (b) [illegible] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 1-14-1947 at 9:30 M

21. I certify that death occurred on the date above stated; that I attended deceased from June 16 19... to Jan. 19 47, and that I last saw him alive on 1-3 1947.

Immediate cause of death	Duration
myocardial failure	
Due to chron. myocardial	6 mo.
Due to arteriosclerosis	2
Other Conditions —	

(Include pregnancy within 3 months of death)

Date of operation —
Major findings of operation: —
of autopsy: —

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence ... at ... M
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature H. L. Summers M.D.
Address 1045 Dulaney Date signed 1-14-47

VS 3

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

00171

176

CERTIFICATE OF DEATH

Reg. Dist. No. 220

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Jessups, Maryland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 months & 27 days.

Hospital, Institution, or street address where death occurred:

Maryland House of Correction

How long in hospital or institution? 2 months & 27 days.

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Anne Arundel

City or town: Jessups,

(If outside city or town limits, write RURAL and give nearest town)

Street No.: Maryland House of Correction

(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: Ike Thomason (alias--Thompson)

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	C	

6.(b) Name of husband or wife:

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): 1885

8. AGE: Years	Months	Days	If less than one day: hrs.	min.
62	?	?		

9. Birthplace: Not Known (Town, county, and state)

10. Usual occupation: Laborer

11. Industry or business: ----

FATHER

12. Name: Not Known

13. Birthplace: Not Known

MOTHER

14. Maiden name: Not Known

15. Birthplace: Not Known

16. Informant: Maryland House of Correction

Address: Jessups, Maryland

17. Buried (Burial, cremation, or removal. Which?) Date thereof: Jan 29 47 (month) (day) (year)

Cemetery or crematory: Mount Auburn

Location: Baltimore, Md.

18. Funeral director: Katie L. Williams

Address: 3227 E. Chase St.

19. Jan 27 1947 (Date rec'd by registrar) Clara Kaelin Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: January 25, 1947 at 3:00 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from October 31 1946, to Jan. 25 1947 and that I last saw h... im alive on January 25 1947

Immediate cause of death	DURATION
Edema of Lungs.	
Due to: Arthritis, Chronic, of Spine--probably tubercular	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: None

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: None Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: John A Clark M.D. M. D. or other

Address: Md. House of Correction Date signed: 1/25/47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

2-30-

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

00172

1317

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH:
County Anne Arundel
City or town Annapolis Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Anne Arundel
City or town Annapolis
(If outside city or town limits, write RURAL and give nearest town)
Street No. 87 Prince George St.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME Jannie Frances Thorogood

3. (b) Social Security Number

4. Sex: Female
5. Color or race: White
6.(a) Single, married, widowed, or divorced: Widow
6.(b) Name of husband or wife: James Thorogood
6.(c) If alive, give age: years
7. Birth date of deceased (mo., day, yr.): Aug 25th 1861

8. AGE: Years: 85 Months: 4 Days: 21 If less than one day: hrs. min.

9. Birthplace: Annapolis Md
(Town, county, and state)
10. Usual occupation: none
11. Industry or business:

FATHER
12. Name: George Norwood
13. Birthplace: Annapolis Md

MOTHER
14. Maiden name: Mary Stallings
15. Birthplace: A A Co Md.

16. Informant: Lottie Thorogood
Address: 87 Prince Geo St. Annapolis Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof Jany 17th 1947 (month) (day) (year)
Cemetery or crematory: St Annes
Location: Annapolis Md
18. Funeral director: John M Taylor & Son
Address: Annapolis Md.
19. Jan 16 1947 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Jan 15 1947, at 8:10 A M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug 5 1946, to Jan 15 1947
and that I last saw h[illegible] alive on Jan 14 1947

	DURATION
Immediate cause of death: Cardio Vascular Failure	48 hrs.
Due to: Cr. Myocarditis	Several Months
Due to: Cr. Nephritis	Several Months
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: J. Oliver Purdie M. D. or other
Address: Annapolis Md Date signed 1/16/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1-35

00173

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 23

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Severn
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Anne Arundel
City or town: Severn R.F.D.
(If outside city or town limits, write RURAL and give nearest town)
Street No.: Menard Ave.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Roland Stanley Tomasik

3.(b) Social Security Number: NONE.

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	White	single

6.(b) Name of husband or wife:
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Nov. 14, 1934

8. AGE: Years	Months	Days	If less than one day
12	2	26	hrs. min.

9. Birthplace: Belmont, Anne Arundel, Maryland (Town, county, and state)
10. Usual occupation: School-boy
11. Industry or business: School

FATHER
12. Name: Bronislaus Tomasik
13. Birthplace: Dubois, Penna

MOTHER
14. Maiden name: Irene Cordrey
15. Birthplace: Hebron, Maryland

16. Informant: Bronislaus Tomasik
Address: Severn P.O., Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof Jan 13 1947 (month) (day) (year)
Cemetery or crematory: Glen Haven
Location: Glen Burnie Md
18. Funeral director: Thomas W. Dunkley
Address: Glen Burnie Md

19. January 1 1947 (Date rec'd by registrar) M. McAlba Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: January 10 1947, at 6.00 P.M.

21. I CERTIFY that death occurred on the date above stated: ~~and I attended deceased from~~ Postmortem Examination
~~and that I last saw him alive on~~ January 10 1947

Immediate cause of death	DURATION
Fracture of neck	sudden
Due to: Internal injures	sudden
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Accident Date of: 1-10-47
Where did injury occur? Severn (City or town) A.A. (County) Maryland (State)
Injured at home, farm, industry, public place (where?): Telegraph Road
Means of injury: Hit by automobile Injured at work? no.

23. SIGNATURE: John M. Claffy M.D., Deputy Medical Examiner
M. D. or other
Address: Annapolis, Md. Date signed: 1-10-47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

00174

Reg. Diat. No. 30-61

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Use correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:
County: Anne Arundel County
City or town: Crownsville, Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 3 mo. 20 days
Hospital, institution, or street address where death occurred:
Crownsville State Hospital
How long in hospital or institution? 3 mo. 20 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County:
City or town: Baltimore City
(If outside city or town limits, write RURAL and give nearest town)
Street No. 602 N. Lanvale St.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: TOMONEY - JAMES

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Black	Widower

6.(b) Name of husband or wife: Eliza Jane
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Jan. 23, 1880

8. AGE: Years	Months	Days	If less than one day
65 ?	------	---	hrs. min.

9. Birthplace: South Caroline
(Town, county, and state)
10. Usual occupation: Farmer
11. Industry or business: ------

FATHER
12. Name: Paris Tomoney
13. Birthplace: St. Paul, S.C.

MOTHER
14. Maiden name: Jenette ---- ??
15. Birthplace: South Carolina

16. Informant: Hospital Records
Address: Crownsville, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof Jan. 12, 1947 (month) (day) (year)
Cemetery or crematory: Family lot
Location: Reminc, S.C.
18. Funeral director: Mrs. George H. Hartman
Address: 1631 Druid Hill Ave.
19. Jan 12 1947 (Date rec'd by registrar) H.E. Naughton Deputy Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: January 9, 1947, at 4:50 P.M.
21. I CERTIFY that death occurred on the date above stated: that I attended deceased from September 20, 1946, to January 9, 1947
and that I last saw him alive on January 9, 1947

Immediate cause of death: Psychosis with General Arteriosclerosis — DURATION: Known to us since admission

Due to:

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Albert L. Strickland M. D. or other
Address: Crownsville, Maryland Date signed: 1/10/47

1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

131a

00175

CERTIFICATE OF DEATH

Reg. Diat. No. 20

1. PLACE OF DEATH:

County: A A

City or town: Edgewater

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 Month

Hospital, Institution, or street address where death occurred:

County Home

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: A A

City or town: Edgewater

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME: William Lee Tydings

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	Single

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): June 10 - 1897

8. AGE: Years: 49 | Months: 7 | Days: 18 | If less than one day: ..... hrs. ..... min.

9. Birthplace: Davidsonville (Town, county, and state)

10. Usual occupation: Farmer

11. Industry or business:

FATHER

12. Name: John Henry Tydings

13. Birthplace: Maryland

MOTHER

14. Maiden name: Frances V. Griffith

15. Birthplace: Maryland

16. Informant: Richard E. Tydings

Address: Davidsonville. Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Jan 29/47 (month) (day) (year)

Cemetery or crematory: Trinity

Location: Woodwardville. Md

18. Funeral director: W. L. Harris & Son

Address: Annapolis. Md.

19. Jan. 29 1947 (Date rec'd by registrar) Edward Callender Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Jan 28 1947, at 12 05 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 27 1947, to Jan 28 1947

and that I last saw h. alive on Jan 27 1947

Immediate cause of death	DURATION
Arteriosclerotic cardio-vascular renal	
Due to disease	?
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: S. Bonsuch M.D. M. D. or other

Address: Annapolis Md Date signed: 1/28/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1-35

00176

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

52a

CERTIFICATE OF DEATH

Reg. Dist. No. 20

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Be sure correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County A.A.

City or town Edgewater

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 35 Years

Hospital, institution, or street address where death occurred: Edgewater

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County A.A.

City or town Edgewater

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Merle Lee . Walker

3.(b) Social Security Number 212-18-4137

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	Single

6.(b) Name of husband or wife

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 27, 1892

8. AGE: Years 54 | Months II | Days I8 | If less than one day ... hrs. ... min.

9. Birthplace Edgewater, Md. (Town, county, and state)

10. Usual occupation Carpenter

11. Industry or business

FATHER 12. Name Thomas W. Walker

13. Birthplace Maryland

MOTHER 14. Maiden name Amanda C. Lee

15. Birthplace Maryland

16. Informant Mrs Amanda C. Walker

Address Edgewater Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof Jan 17-44 (month) (day) (year)

Cemetery or crematory Hope Chapel

Location Edgewater, Maryland.

18. Funeral director B.L.Hopping & Son

Address Annapolis, Md.

19. Jan. 17, 1947 (Date rec'd by registrar) Edward Collemin Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH January 14, 1947 M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Jan 1, 1945 to January 14 1947 and that I last saw him alive on January 14 1947

Immediate cause of death

Carcinoma of Liver

DURATION: Since 1/1/47

Due to

Due to

Other conditions Carcinoma of Kidney Since 1/1/47

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Albert H. Wiedorn M. D. or other

Address Annapolis Md. Date signed 1/14/47

2-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

191 6 ★ 00177

CERTIFICATE OF DEATH

Reg. Dist. No. 27

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Fort George G. Meade, Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 8 Days
Hospital, Institution, or street address where death occurred:
Station Hospital
How long in hospital or institution? 8 Days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: District of Columbia County:
City or town: Washington 19
(If outside city or town limits, write RURAL and give nearest town)
Street No. 5041 Just Street, N. E.
(If rural, give LOCATION)
2.(a) If veteran, name war: World War I

3. (a) FULL NAME: CHARLES S. WASHINGTON

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Negro	Married

6.(b) Name of husband or wife: Mary Washington
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): March 23, 1888

8. AGE: Years	Months	Days	If less than one day
58	10	6	hrs. min.

9. Birthplace: Canton, Illinois (Town, county, and state)
10. Usual occupation: Unemployed
11. Industry or business:

FATHER
12. Name: unk.
13. Birthplace:

MOTHER
14. Maiden name: unk.
15. Birthplace:

16. Informant: Medical Records
Address: Sta Hosp, Ft Geo G Meade, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: 30 January 47 (month) (day) (year)
Cemetery or crematory: Arlington National
Location: Arlington Va

18. Funeral director: W. Emmett Jarvis & Co
Address: 1432 U St NW Washington DC

19. 30 January 1947 (Date rec'd by registrar) Bernard F. Kerwin, Registrar

MEDICAL CERTIFICATION

755 PM

20. DATE OF DEATH: 29 JAN 1947 (1955) M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 29 Jan 1947 to 29 Jan 1947 and that I last saw h[im] alive on 29 JAN 1947

Immediate cause of death	DURATION
Cardiorespiratory failure	
Due to: Uremia	3 days
Due to: Terminal Chronic Glomerulo-nephritis	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operation: None Date of op.

Autopsy results: Confirmed

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Paul Cutler Lt. M.C. M. D. or other
Address: Ft. G. Meade, Md. Date signed: 30 Jan 47

PC.

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

2-25

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

93d

00178

Reg. Dist. No. 250

1. PLACE OF DEATH:

County A. A. County

City or town Baltimore - 25 (Brooklyn)

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 8 yr.

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County A. A.

City or town 406 Dillwood Ave

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Isaac Henry Whittington

3.(b) Social Security Number 220-18-9735

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widowed

6.(b) Name of husband or wife Sarah Ja

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Sept. 22 - 1872

8. AGE: Years	Months	Days	If less than one day
74	3	10	....hrs. ....min.

9. Birthplace Marion Md.
(Town, county, and state)

10. Usual occupation Carpenter

11. Industry or business

FATHER 12. Name Stephen Whittington

13. Birthplace Marion Md.

MOTHER 14. Maiden name Lisa Jane Handy

15. Birthplace Marion Md.

16. Informant Mrs Ja Fisher

Address Same -

17. Burial (Burial, cremation, or removal. Which?) Date thereof Jan 5th 1947 (month) (day) (year)

Cemetery or crematory St. Pauls

Location Marion Md.

18. Funeral director William Cook Inc

Address 1217 St. Paul St.

19. —3-47 (Date rec'd by registrar) 19..... Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Jan 2 1947 at 12:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec. 15 1946 to Jan 2 1947

and that I last saw him alive on Jan. 1 1947

Immediate cause of death	DURATION
Cardio Vascular Disease	2½ mos
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Chas. L. Ball Jr. M.D.
M. D. or other

Address Linthicum Date signed 1-2-47

MARGIN RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

97

00170

CERTIFICATE OF DEATH

Reg. Dist. No. 28

1. PLACE OF DEATH:

County Anne Arundel County

City or town Crownsville, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 4 months 10 days

Hospital, institution, or street address where death occurred:
Crownsville State Hospital

How long in hospital or institution? 4 months 10 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Prince George's

City or town Brandywine
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Wills - James

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Negro	Widowed

6.(b) Name of husband or wife Unknown

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) 1880

8. AGE: Years	Months	Days	If less than one day
66	Unknown		——— hrs. ——— min.

9. Birthplace Unknown
(Town, county, and state)

10. Usual occupation Laborer

11. Industry or business -----

FATHER
12. Name Lee Wills
13. Birthplace Unknown

MOTHER
14. Maiden name Judity Hawkins
15. Birthplace Unknown

16. Informant Hospital Recrods

Address Crownsville State Hospital, Md.

Buried (Burial, cremation, or removal. Which?) Date thereof January 13,1946 (month) (day) (year)

Cemetery or crematory T. B. M. E. Cemetary

Location T. B, Maryland

18. Funeral director Huntt and Ryon

Address Waldorf, Maryland

19. 1/11 47 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH January 10, 1947 at M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from August 30 1946 to January 10 1947

and that I last saw him alive on January 10 1947

Immediate cause of death General Arteriosclerosis — DURATION: Known to us since admission August 30,1946

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operation

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE [signature] M. D. or other

Address Date signed

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1-35

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

146 00180

Reg. Dist. No. 23

1. PLACE OF DEATH:

County: A.A. County

City or town: Delmont Station, Severn Md.

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: A.A.

City or town: Delmont Station, Severn Md.

(If outside city or town limits, write RURAL and give nearest town)

Street No.: Delmont Station Severn Md.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: ELIZABETH ZILISH

3.(b) Social Security Number: **********

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
FEMALE	WHITE	WIDOWED

6.(b) Name of husband or wife: Gerhardt Zilish

6.(c) If alive, give age: D.a. years

7. Birth date of deceased (mo., day, yr.): 11 - 29 - 1859

8. AGE: Years: 87 Months: -- Days: 6 If less than one day: ********** hrs. ********** min.

9. Birthplace: Hungary (Town, county, and state)

10. Usual occupation: Housewife At Home

11. Industry or business:

FATHER — 12. Name: John Shever

FATHER — 13. Birthplace: Hungary

MOTHER — 14. Maiden name: Unknown

MOTHER — 15. Birthplace: Hungary

16. Informant: Mrs. John Blase

Address: Delmont Sta. Severn, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: 7 Jan. 47 (month) (day) (year)

Cemetery or crematory: Holy Cross Cemetery

Location: Maryland

18. Funeral director: F. B. Wippert & Son

Address: F.B.WIPPERT & SON 1300 EUTAW PLACE..17

19. Jan 6- 1947 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 4th. JANUARY 47 19..., at 5:30 A M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from 11/10/45 19... to 1/4/47 19...

and that I last saw her alive on 1/3/47 19...

Immediate cause of death	DURATION
Carcinoma	
Due to	1½ yr
J Smith	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: John Schumacher M. D. or other

Address: Glen Burnie Date signed: 1/6/47

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING